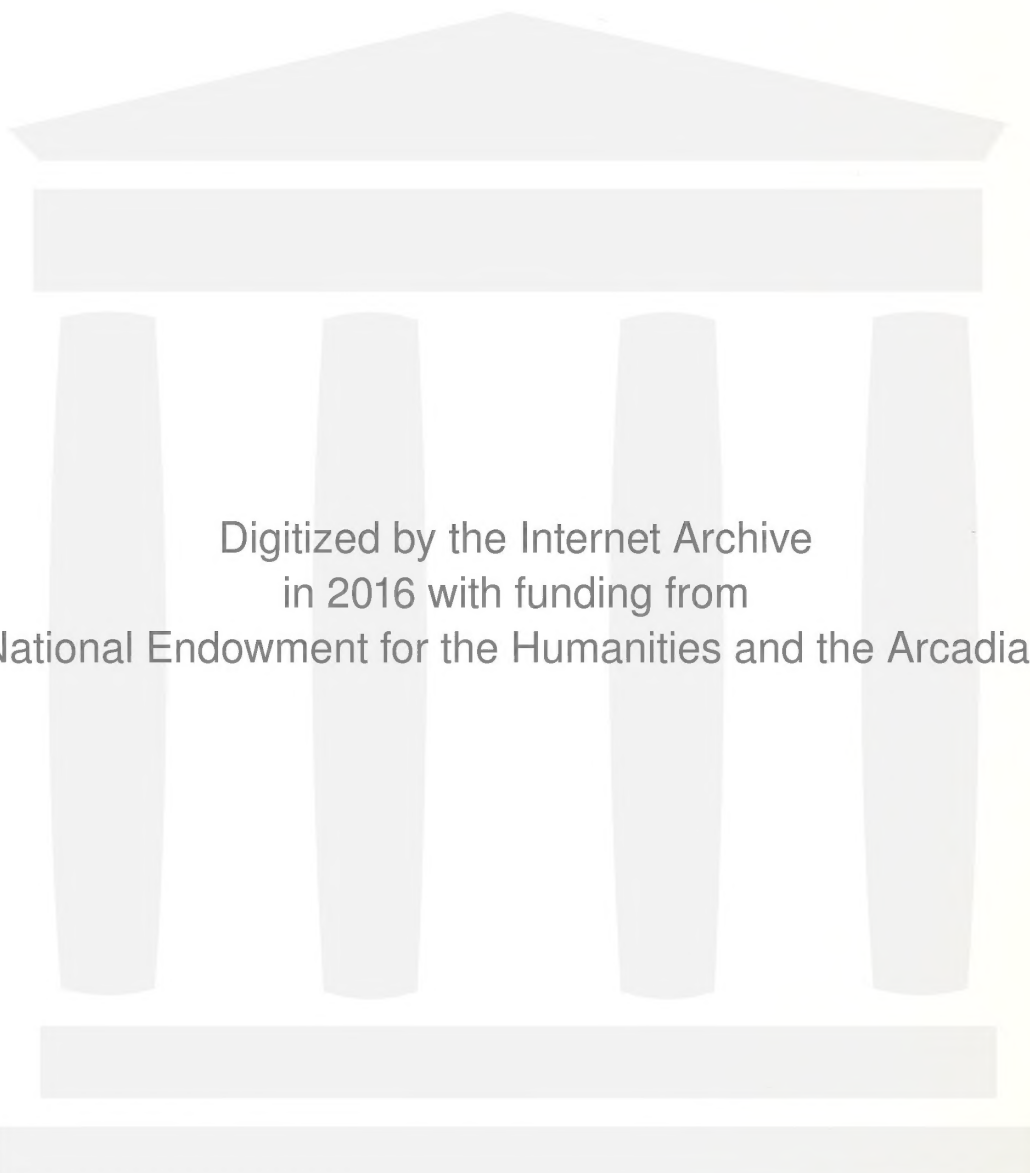


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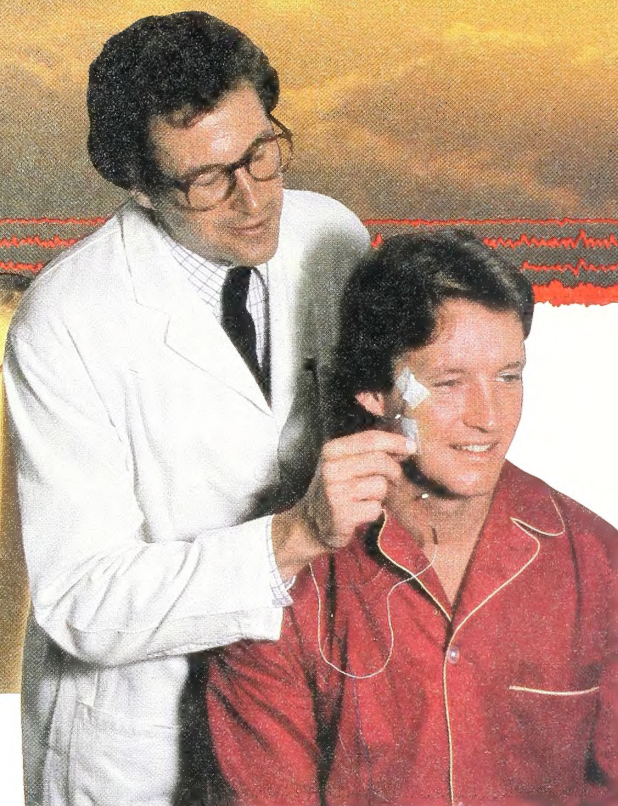
Vol. 79, No. 1, January, 1983

**MEDICINE
and
POLITICS**

The annual checkup

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In the treatment of insomnia

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Dalmane (*flurazepam HCl/Roche*)
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with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

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Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.⁴ The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.⁵⁻⁸ Since the risk of oversedation, dizziness, confu-

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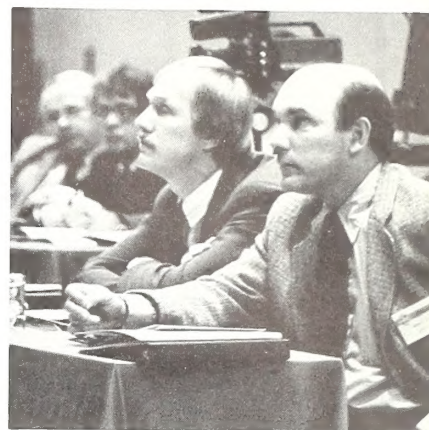
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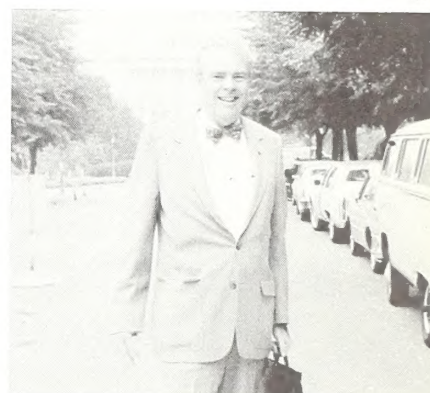
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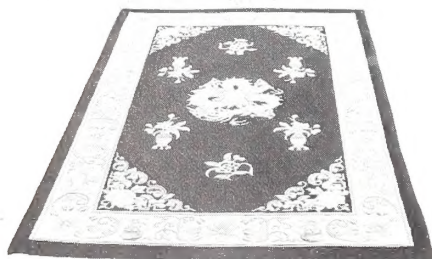
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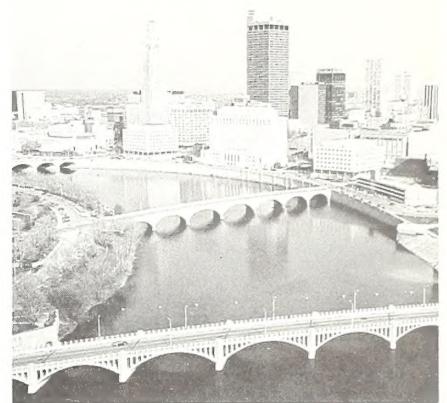
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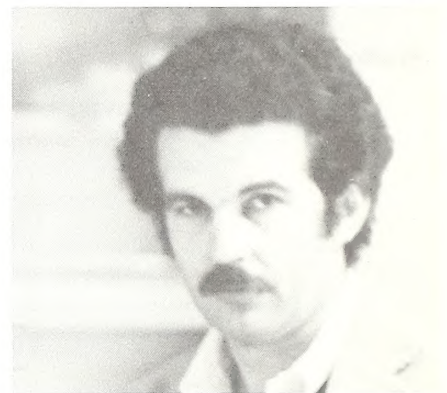
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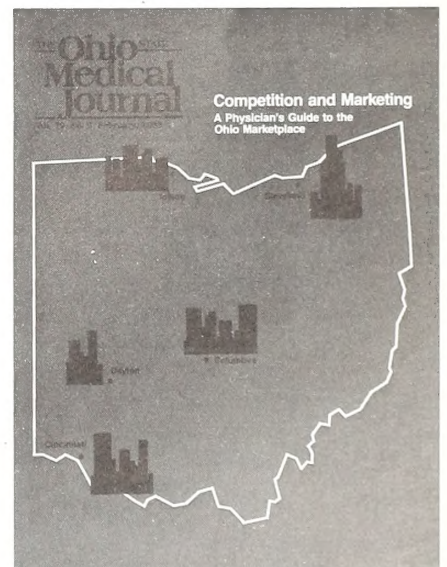
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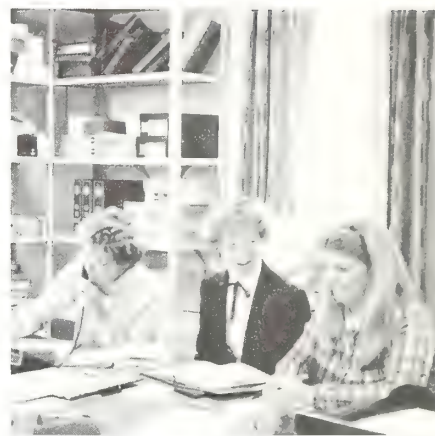
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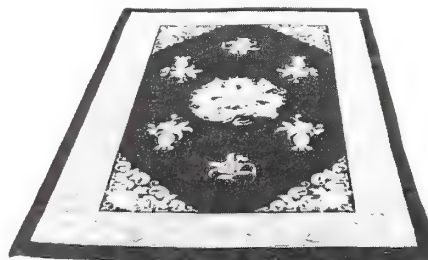
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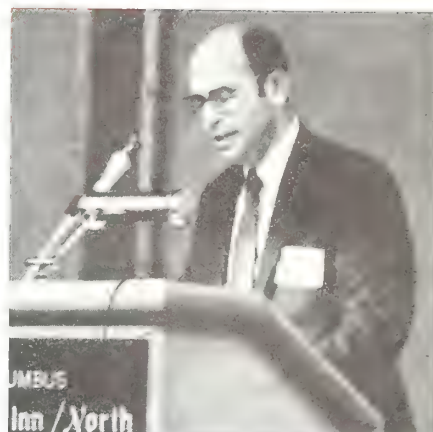
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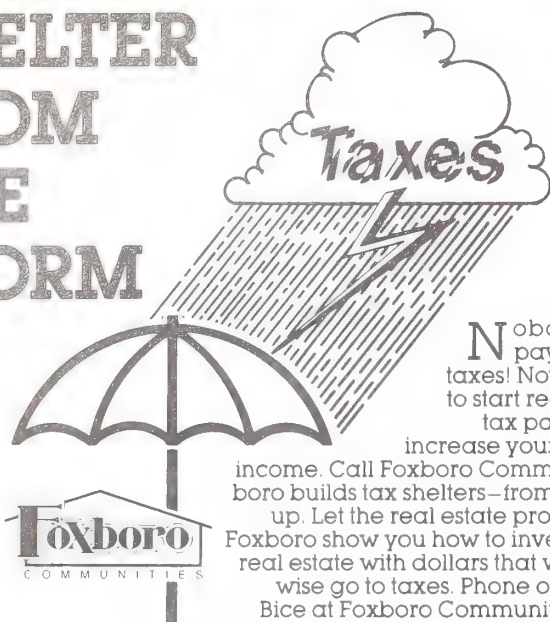
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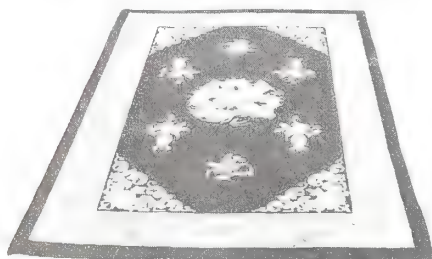
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— David Masland, M.D.
Pennsylvania Medicine

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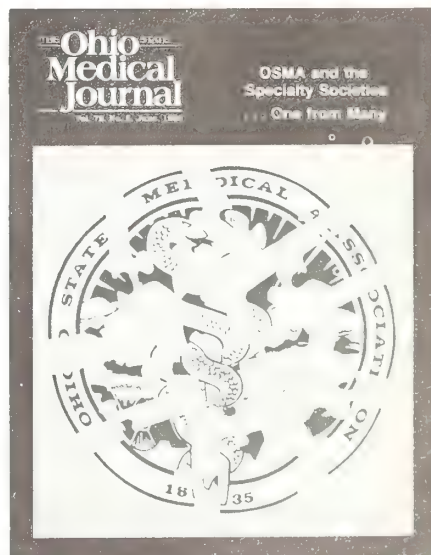
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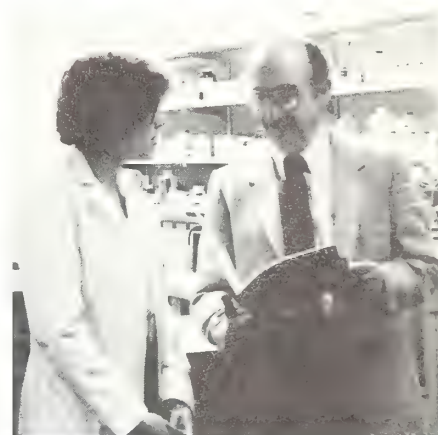
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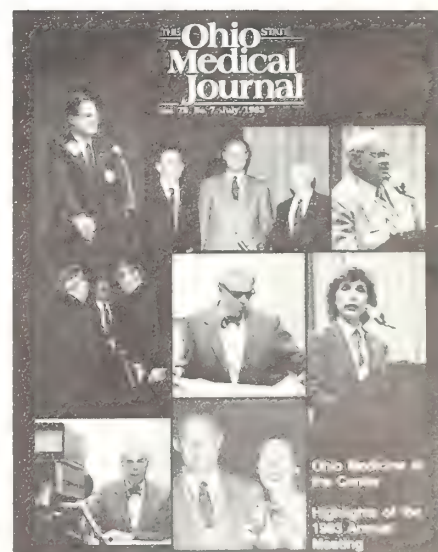
Top left: S. Baird Pfahl, M.D., President-Elect, presided over this year's Annual Meeting. Top center: Stewart B. Dunsker, M.D., Immediate Past President; Dr. Pfahl; and Hart Page, OSMA Executive Director. Top right: Philip B. Hardymon, M.D., presented AMA-ERF checks. Middle left: W. Jack Lewis, M.D.; A. Burton Payne, OSMA's new President-Elect, and John McLaughlin, this year's OMPAC speaker. Middle center: C. Douglass Ford, M.D., OSMA President, was unable to attend the Annual Meeting due to illness. Here, he prepares his Presidential address which will be videotaped for the Meeting. Middle right: Mrs. Rose Vesper, OSMA Auxiliary President. Bottom left: Dr. Ford, in front of the videotape camera. Bottom center: Dr. and Mrs. Pfahl.



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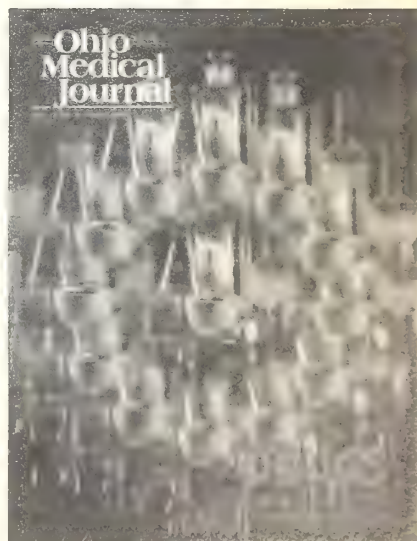
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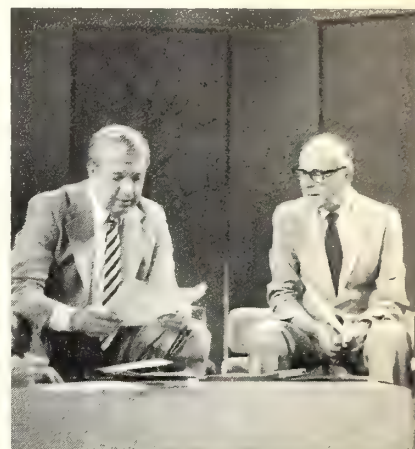
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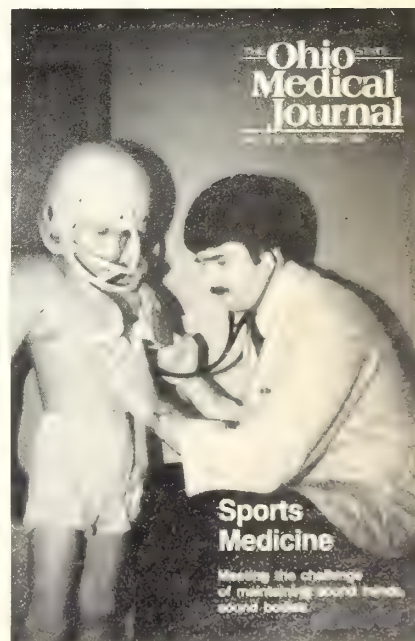
Paul Dusseau, M.D., Columbus, takes a moment to examine his son, Joe, before football practice. Photo by Rebecca J. Doll, Director, OSMA Department of Communications.



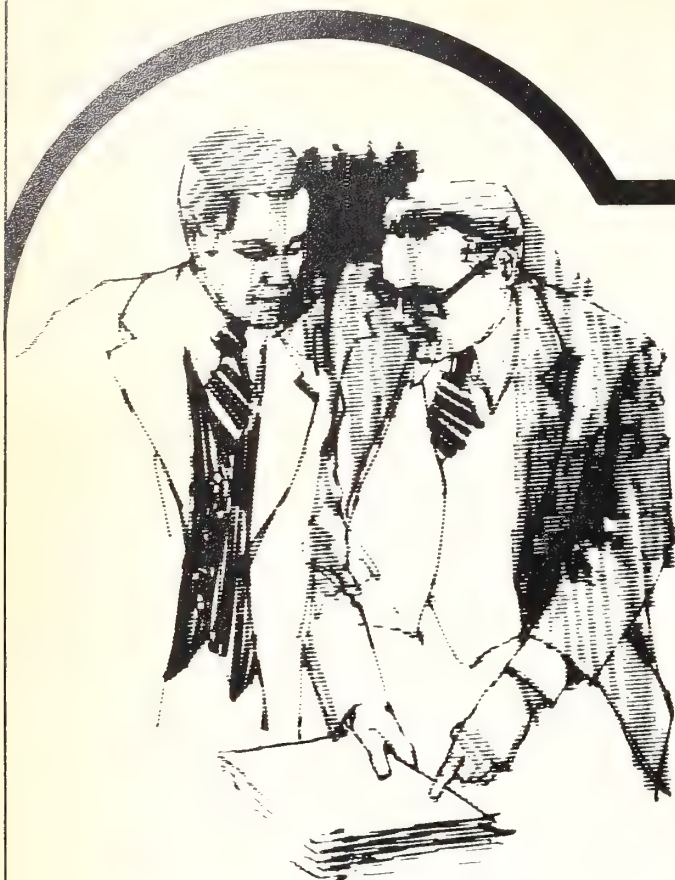
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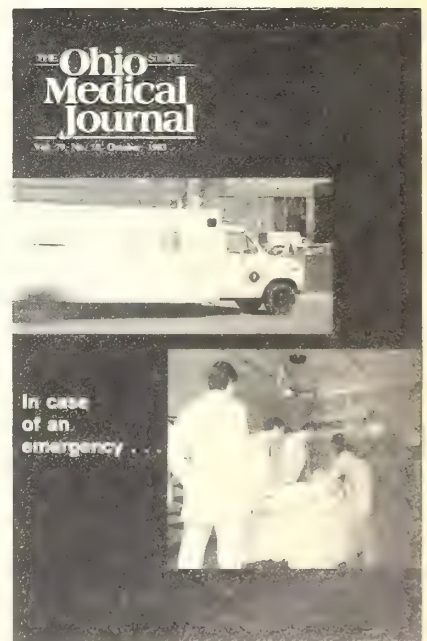
Free-lance photographer Larry Hamill provided us with the picture of the ambulance in motion, and the Public Relations Department of Riverside Hospital provided us with the Emergency Room photograph.



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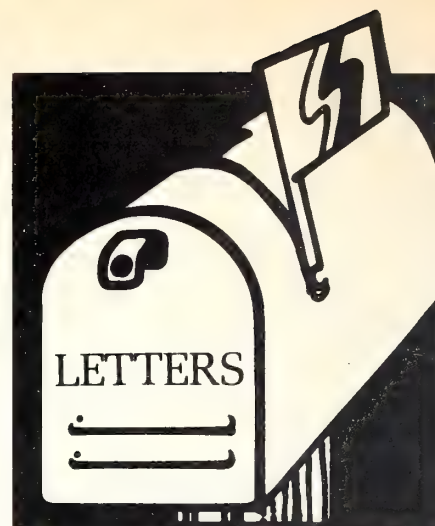


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Letters ... to the editor

(The OSMA Journal welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.)

To the Editor:

I found the recent article on ocular changes in Graves' Disease (August Journal), very worthwhile, but was chagrined at the omission of a frequently successful, but as yet not-FDA-approved treatment with metronidazole. I suggest that the authors check with their female patients who had concomitant therapy for trichomoniasis, and then report their findings, and the changes which occurred in the status of the patients' exophthalmos.

Sincerely,
Eduard Eichner, M.D.
Cleveland Heights, Ohio

Correction

In the article "Guidelines for Proper Prescribing" by Frank Wickham, in the August issue of the Journal, Mr. Wickham wrote that Lomotil and Phenergan with Codeine were among the Schedule V drugs that could be purchased from a pharmacy without a prescription. In fact, both drugs must be prescribed by a physician before they can be purchased. The Journal regrets any confusion that may have been caused by the error.

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Stephen E. Peterson, PhD and Alvin E. Rodin, MD

Are Ohio's medical schools overpopulating the state with physicians? Two physician-educators take a look at the situation as it exists now and at its future implications.

The DRGs . . . Have Arrived! 831

Karen Edwards and Susan Porter

The DRG seminar, sponsored early this fall by OSMA and the Ohio Hospital Association, provides some last minute insight into the new Medicare payment system which was put into effect this past October.

Reducing the Pressure 833

Susan Porter

For the past six months, most of Ohio's medical societies have sponsored a program which insured that the health needs of their area's indigent would be met. Now these societies are reviewing the progress of their programs . . . and deciding whether or not they should continue in the future.

Unemployment and the Suicide Rate 837

Robert G. Filby, MDA and Geary M. Eicher, Jr., MD

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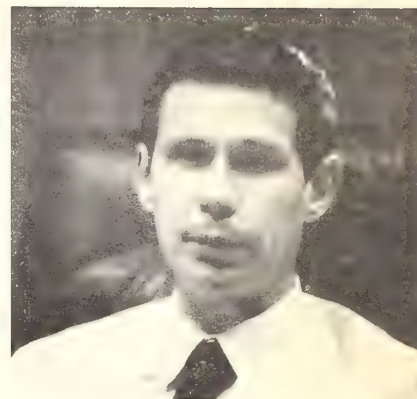
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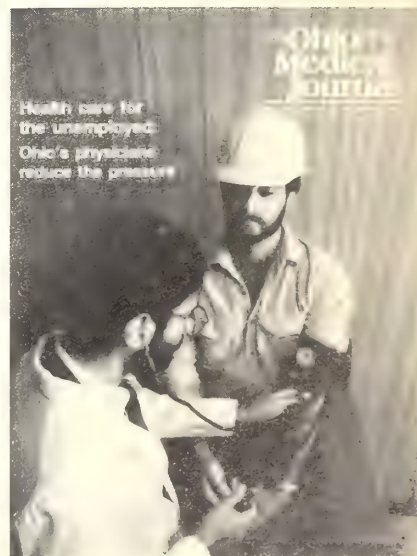
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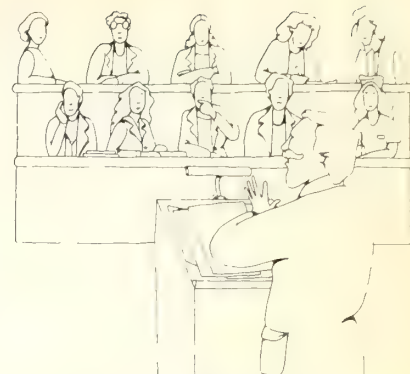
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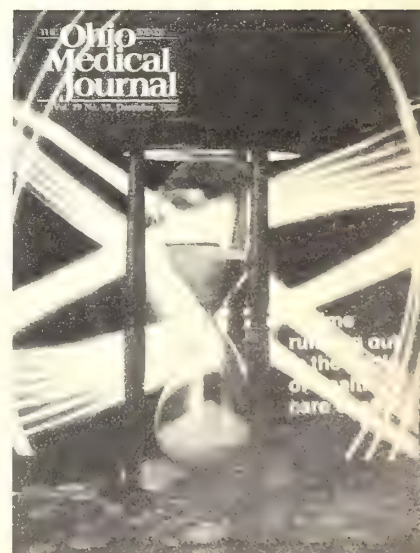
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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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Political involvement Making Miss Irwin proud

By C. Douglass Ford, M.D.

Miss Mary Irwin, my sixth grade teacher, was strong on citizenship. When she taught what then was called civics, she was uncompromisingly disdainful of those who, in her eyes, failed to discharge their duties as citizens. Someone who did not vote, did not formulate and express an opinion, or did not have some concern for community affairs — any of these or other transgressions which constituted an evasion of duty would earn her disapproval. Miss Irwin's ire was awesome; but her disapproval was something any sensible sixth grader would avoid with all means available.

To this day, I do not understand why some appear to avoid their "civic duties" without guilt. Maybe Miss Irwin's counterparts were not as formidable to their charges as she seemed to me. Inside, I know she was correct. Certainly, I am unwilling to evoke her disapproval even yet — wherever she may be.

How about you? Did you vote this past November? Are you informed about the issues? Will you voice your opinion when and where it counts? If not, your Miss Irwin (I hope she exists) may get you.

A greater percentage of the electorate voted in this past election than had done so in the past several elections. Obviously, more Ohioans voted for the Democratic candidates than for the Republican ones. I'm told that labor leaders again were more effective in getting their members to vote. Senior citizen leaders persuaded

their constituents to vote; and more voted Democratic. Other forces were at play, as well. Whatever the election result, I was taught by you know who that that is the essence of the American way.

I cannot recall how many years it has been since one party won such complete control in Ohio. This issue of the *Journal* addresses some of the effects of Ohio politics upon Ohio medicine. Many political issues which are decided in Columbus have national importance and attract the attention of the "big league" players. When you are politically just an ordinary doctor, it may seem unlikely to you that you can influence legislative events. I know better.

When you are politically just an ordinary doctor, it may seem unlikely that you can influence events. I know better.

The OSMA legislative department will be working with party leaders in the Ohio Senate who, in the past, have supported legislation which the OSMA Council supported or vice versa. Leaders and members of the Ohio House probably will have legislative goals which may not parallel ours at times. The



C. Douglass Ford, M.D.

Department's lobbying effectiveness will continue only if you support our legislative positions with personal communications to your Senator and representatives.

The fact that the majority of these lawmakers are affiliated with the Democratic party does not reduce them to a patella-like reflex compliance to their party leadership's wishes. Legislators still will be responsive to their constituencies in most cases and with most issues. They are not party hacks who thoughtlessly follow someone when they vote. Much depends upon the news from home — the letters from you carry our clout.

During the next two years OSMA Council will, I'm certain, develop proactive and reactive legislative positions. Nearly all of the 400-plus bills introduced annually will be monitored and evaluated. Where appropriate, Council will adopt a legislative position. Your role will be to write to your lawmakers when you can support the OSMA position. That series of letters which you send to them will reinforce our legislative efforts on behalf of our patients and our members.

continued on page 8

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Cutting down on forms and reducing time-consuming claims handling are important advantages of the new ADVANCE Plan agreement, now being introduced by Ohio Medical Indemnity Mutual Corp., the Blue Shield Plan headquartered in Worthington. The streamlined claims handling procedures designed into the program can reduce your administrative costs — and ours at OMIM as well. The agreement asks that

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SECOND OPINION

Return-to-Work Responsibilities

By K. D. McMurrain, Jr., M.D.

The Second Opinion in the August 1982 edition, "Pigeons are Gray . . . and Other Important Facts," by Brooks Mick, M.D., points out some profound return-to-work responsibilities for physicians.

If medical findings determine it is proper to permit an employee to remain on a medical disability and off work, no one will question that decision. However, if it becomes a favor or special dispensation because (s)he is a good patient, or that you have treated the family for years and you don't want to lose a patient, that is unethical and creates a problem for industry and will ultimately create a problem for you and your patient as well.

To provide you with some background on this problem, a recent survey of five major companies in the Cincinnati area revealed that over 70% of employees, absent for more than five days, return to work on Monday. This is statistically improbable! For the patient seen by the physician on Tuesday, Wednesday, or Thursday, that means anywhere from three to five days additional medical pay which industry must pay. Benefits are for the protection of the sick or disabled employee, not the well or recovered employee. These payments represent bottom line profit dollars. . . dollars

that could go into employee wage increases or into capital investments to improve our competitive position against subsidized foreign imports.

Any increase in health benefit premiums will accelerate industry's interaction with health care coalitions who will ultimately demand that Medicine respond like any other supplier of services. Those who pay the bill are going to have something to say about the expected quality and

Some physicians don't realize they are going to strangle the goose that lays the golden egg . . .

quantity of services. Industry now pays over 40% of the total dollars spent on health care benefits, government pays a slightly higher amount, and the remainder are private cash customers. In high unemployment areas, physicians also have been suffering because these people have lost their health coverage and do not schedule office appointments, even for needed medical attention.

Some physicians don't realize they are going to strangle the goose that lays the golden egg. Industry is there to make a profit — the same as physicians! There should be no argument about the need for cooperation. Industry is not asking physicians to do anything immoral, they are just asking them to be honest and play it straight! Industry can afford to pay for sick or injured employees, but the "freeloaders" are pulling them down. Most employees will applaud your efforts in promptly returning these people to work. If the individual does not want to work, then that is a personnel problem industry can handle. But don't let these individuals use you by hiding behind your stethoscope or your medical reputation.

Consider this the next time you start to write a disability certificate for a patient to take an extended paid medical leave of absence. Call the plant physician, if there is one, or the personnel manager, to see if they can arrange for a job modification to accommodate any concerns you have about the employee performing his or her job.

When you discharge patients, direct them to the company medical department or personnel manager right away, and don't allow them to

Return-to-work Responsibilities

(continued)

wait until "next Monday." Industry wants employees working if there is no danger to their health. However, if industry will not take them back and you believe they are not disabled, don't sign a disability certificate! Suggest that they put the employee back on the payroll and quit blaming the medical profession for this increased medical cost.

You might believe that you don't need industry, but your patients do. We all have to do what we reasonably can to keep industry alive and profitable in Ohio. Our schools need industry, our roads need industry, our hospitals need industry, and you need industry as well, whether you want to admit it or not. A successful industrial base will serve to keep services up in a way that will make Ohio a better place to live.

Our schools need industry, our hospitals need industry . . . and you need industry, too, whether you want to admit it or not.

You have a similar responsibility to encourage minimal hospital stays and the use of outpatient facilities to help contain the rise in health care costs. If Medicine does not respond to these challenges, the general medical standards and quality of life in this country are going to continue taking a severe beating. We must then look to ourselves to be a part of the solution rather than a part of the problem.

These comments are not directed to the many dedicated physicians who truly recognize their responsibility in keeping people at work, but it is necessary for all physicians to tell patients it is your expectation that they will return to work as soon as possible, and to not ask you for any special or unethical favors such as disability certification for unsubstantiated medical absence.

K.D. McMurray, Jr., M.D. practices occupational medicine in Cincinnati, Ohio

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President's page

(continued)

It is not un-American to try to influence your legislator's vote, nor is it un-American to support your association's position on a given issue. Likewise, it is not un-American to hold a position different than the OSMA's position. It may not be un-American to be disinterested in the whole process or to do nothing; but it is totally ineffective. And you will not get Miss Irwin's approval.

We will keep you informed. Read and act upon the information we send to you. Send your opinions to us, as well. Council and the legislative committee welcome thoughtful membership input. Miss Irwin expects you and I to pay attention. She believed that was another one of your duties. You don't want her disapproval, believe me.

C. Douglass Ford, M.D., Toledo, is President of the Ohio State Medical Association

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COLLEAGUES IN THE NEWS



D. N. BEDDARD, M.D., a general internist in Mansfield, was elected to the board of the Ohio Society of Internal Medicine.

JAMES BLACKFORD, M.D., Columbus, was appointed medical director of Riverside Methodist Hospital's peripheral vascular laboratory.

DUDLEY BRIGGS, M.D., Columbus, was elected chairman of the board of trustees of Peer Review Systems, Inc. Dr. Briggs is medical director of Western Electric. **CHARLES HARDING, M.D.**, of Harding Hospital, was elected president.

Also elected were **HARRY TOPOLOSKY, M.D.**, vice-chairman, and **WILLIAM BACON, M.D.**, vice-president.

RICHARD E. CHRISTIE, M.D., Cleveland, was named director of family practice at St. Luke's Hospital and director for the family practice residency program functioning in Solon. Dr. Christie is also director of ambulatory services at St. Luke's; assistant professor of family medicine and medicine; and director of the CORE clerkship, 4th year ambulatory medicine at Case Western Reserve University School of Medicine.

ALFRED DEMARIA, M.D., Columbus, was appointed medical director of Riverside Methodist Hospital's EEG laboratory.

JERRY L. HAMMON, M.D., West Milton, was appointed vice-president for medical affairs at Good Samaritan Hospital. Dr. Hammon has been a delegate to the American Medical Association's House of Delegates for the past six years, and has served since 1978 as chairman of the OSMA's Committee on Scientific Work.

JAMES JACOBSON, M.D., Cleveland Heights, was appointed director of the department of psychiatry at the Mt. Sinai Medical Center. Dr. Jacobson is an assistant clinical professor of psychiatry at Case Western Reserve University School of Medicine.

BRUCE JANIAK, M.D., Toledo, was elected vice-president of the American College of Emergency Physicians (ACEP). Dr. Janiak is the Director of the Emergency Department at Toledo Hospital, and has previously served ACEP as president of the Ohio Chapter, as well as secretary-treasurer at the national level. Dr. Janiak is serving his third year on the Board. In the same election, **MICHAEL E. ERVIN, M.D.**, Dayton, was elected to a three-year term on ACEP's Board of Directors. Dr. Ervin is the Director of the Emergency Department at Miami Valley Hospital, Dayton, Ohio.

JOHN C. JOHNS, M.D., Akron, was appointed medical director of Summit Health Guard. Dr. Johns is associate professor of medicine at the Northeastern Ohio Universities College of Medicine, and director of medical education and chief of the diabetes-endocrinology services at Akron General Medical Center.

CLYDE L. NASH, JR., M.D., Shaker Heights, was appointed director of the department of surgery at St. Luke's Hospital. Dr. Nash is an associate professor of orthopedics at Case Western Reserve University School of Medicine, and an associate professor in the school's Division of Research in Medical Education. He is also president-elect of the Scoliosis Research Society and has published numerous articles on scoliosis, the spine and spinal cord monitoring in various journals.

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Michael E. Ervin, M.D., Dayton, new Emergency Group Board Member.



Jerry L. Hammon, M.D., West Milton . . . vice-president, medical affairs, Good Samaritan Hospital.



John M. Tew, Jr., M.D., Cincinnati, new president of the Congress of Neurological Surgeons.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

Pac Man move over — Killer T-Cell designed to educate and entertain

It was just a matter of time. A researcher at the University of Texas M.D. Anderson Hospital and Tumor Institute has come up with a brand new electronic game — Killer T-Cell.

In the game, designed to educate as well as entertain, players track down cancer cells and destroy them, using a T-Cell (known professionally as a T-lymphocyte).

Killer T-Cell is based on the biological principles involved in the body's natural defense mechanism against cancer. "As in real life, the cancer cells divide exponentially, and invade and destroy normal tissue. With the player's help, the T-cell has to track down the cancer cells and destroy them," says Elton Stubblefield, Ph.D., the game's designer.

If the cancer cells get out of hand and the players have enough points, they may exercise the option to use chemotherapy or anticancer drugs to help. "But this costs points in the game, because chemotherapy, as in reality, has a cost to the patient," Stubblefield explains. Chemotherapy may kill off some of the cancer cells, but not all of them.

Should the player lose a game, he or she suffers a "relapse," a term that means the signs and symptoms of cancer have returned and the patient has suffered a setback in recovery. The battle isn't over, but the player has to start over at a lower game level.

Killer T-Cell will be marketed as a disk for use with the Apple Home Computer.

Some people may be genetically/socioculturally predisposed to becoming alcoholics

Recent data, collected by Robert Cloninger, M.D., of the Washington University and Jewish Hospital, St. Louis, indicates that certain individuals may be genetically as well as socioculturally predisposed to becoming alcoholics.

According to the data he and his colleagues have collected, environmental factors are not necessarily the primary cause of alcoholism. Some figures have indicated that both environmental and genetic factors were responsible for transmission of alcoholism from biological parents to their children.

The researchers differentiated between two types of alcohol abuse, and the extent to which sex of the offspring, and heritability played a determining role in the development of alcoholism.

Type I or "milieu-limited" alcoholism, found to be the most common form, occurs in men and women who begin drinking as young adults and develop drinking problems by middle age, Dr. Cloninger noted.

High-risk alcoholic liver disorder and hospitalization are consequences mainly associated with Type I

alcoholism, he said. Antisocial behavior and social and occupational problems are not as prevalent among alcoholics of this type, however.

"We found that natural children of parents who have this type of

of alcoholism, "male-limited" alcoholism.

Swedish data suggest the heritability of predisposition to Type II alcoholism is 90% in men. This type of alcoholism, however, is much less common than Type I alcoholism. Prominent social problems but few medical complications may accompany Type II alcoholism, according to Dr. Cloninger.

Most damaging to the supposition that alcohol abuse is a learned action was evidence that alcohol abuse in adoptive parents did not increase the risk of either type of alcoholism in sons or daughters, Dr. Cloninger pointed out.

"Thus, resemblance of parents and children with regard to alcohol abuse is not due to imitation or social learning, as some have suggested."

Dr. Cloninger said one might infer from the data available that if an individual is predisposed to becoming an alcoholic, he or she might avoid that path through control of social drinking — through not drinking to intoxication. "But that may be a difficult message to sell," he acknowledged.



alcoholism have a twofold greater risk of developing alcoholism themselves," he related.

Genetic factors appear to play a greater role, however, in a second type



Chest pain not always symptomatic of heart disease

As many as 20% of patients who visit emergency rooms with chest pain may have symptoms caused by disorders of the esophagus rather than the heart, writes a British researcher in a recent issue of the *Journal of the American Medical Association*.

Dr. Huw Alban Davies and colleagues at the University Hospital of Wales, Cardiff, studied 77 emergency room patients with chest pain symptomatic of heart disease. They found no evidence of heart disease in 26 of the patients. Among that group, esophageal disorders — spasm and sensitivity to digestive acid — were the cause of pain in eight patients and were probably responsible for symptoms in eight others. "This means that for emergency medical admissions with anginal chest pain, as many as one out of five are due to esophageal disease," says Dr. Davies.

However, when an episode of chest pain leads to emergency hospital admission, a patient should be suspected of having a heart attack, he notes.

Anyone suffering from severe or unusual chest pain should go to the hospital immediately, says Richard J. Jones, M.D., director of the AMA's Division of Scientific Analysis and Technology. "It can be dangerous to delay medical attention in the belief that your symptoms might be due to some problem other than heart disease. A physician would rather see many patients with indigestion in the emergency room than miss one patient with a heart attack who was too embarrassed to come to the hospital," he emphasizes.

Patient survives briefly with few circulating red blood cells

For what is believed to be only the second time in medical history, a patient was able to survive briefly with few, if any, circulating red blood cells.

The first such case, reported in 1967, saw that patient survive for two hours, fully conscious.

In this most recent incident, reported in an issue of the *Journal of the American Medical Association*, a severely ill woman remained alive and

lucid for almost five hours, despite the fact that virtually all of her red blood cells were destroyed.

Both patients had been suffering from cancer, and were infected by similar bacteria, whose toxins can lead to the destruction of red blood cell membranes. Both apparently survived because natural hemoglobin, released by the bursting red blood cells, was effective in transporting oxygen.

BOOK SHELF

Drug Interactions Index by Fred Lerman, M.D., and Robert T. Weibert, Pharm D., Medical Economics Books, Oradell, New Jersey, \$17.50.

Structured on a unique, numbered index system, this new book both speeds up and simplifies the search for drug interaction information. **Drug Interactions Index** allows the reader to find any of its 341 drug-drug or drug-food interactions in seconds. Trade-generic drug name conversion is instantaneous, and determining interactions involving drug classes and combination products is quick.

Each of the 341 interaction descriptions is a concise precis that highlights the essential facts most useful in actual clinical practice. The descriptions include suggestions for treating, minimizing and preventing adverse effects.

Drug Interactions Index is available at \$17.50 plus \$1.50 handling charge, from Medical Economics Books, Box 157, Florence, Ky 41042.

Frederick P. Zuspan, M.D., of Ohio State University and William F. Rayburn, M.D., of the University of Michigan, have collaborated on a book which details up-to-date information concerning "Drug Therapy in Obstetrics and Gynecology."

"This book is unique in that it brings together the knowledge and skills attained by physicians, pharmacologists and pharmacists through clinical practice and research," said Clifton J. Latiolais, director of the department of pharmacy at Ohio State University Hospitals, and an associate editor.

The three-part book deals with drugs' effects on obstetrics, on gynecology, and finally, general use medication such as antibiotic, anticoagulant and psychoactive drugs.

Obstetrics chapter topics range from the effects of drugs on the fetus and the use of anticonvulsants, to the management of pain during labor and drugs in breast milk.

The section on gynecology includes chapters on oral contraceptives, over-the-counter drugs and chemotherapy in gynecological oncology.

Associate editors include Latiolais; Philip J. Schneider, associate director of the department of pharmacy at Ohio State University Hospitals; and Brian D. Andresen, associate professor of pharmacology.

Colleagues in the News

(continued)

WILLIAM MILLHON, M.D., was elected president of the medical and dental staff of Riverside Methodist Hospital, Columbus, and **JAMES BAIRD** was named president-elect. Also elected were: **JEROME GAUTHIER, M.D.**, anesthesia; **SAMUEL KIEHL, M.D.**, emergency medicine; **JOHN VERHOFF, M.D.**, family practice; **DAN McFARLAND, M.D.**, radiology; **MELVIN OLIX, M.D.**, surgery; and **HERBERT DERMAN, M.D.**, pathology.

GEORGE PAULSON, M.D., Columbus, is a member of the cost containment organization of the Coalition of Cost Effective Health Services, and **JAMES BARNES, M.D.**, Columbus, is a member of the group's education and research organization.

RALPH A. STRAFFON, M.D., Cleveland, was elected vice-president of the Council of Medical Specialty Societies. Dr. Straffon is a representative to the CMSS from the American Urological Association and has served on the board of directors since 1981.

JOHN M. TEW, JR., M.D., Cincinnati, is the new president of the Congress of Neurological Surgeons. Dr. Tew is director of the Mayfield Neurological Center at Good Samaritan Hospital.

MANUEL TZAGOURNIS, M.D., was elected to the board of directors of Midland Mutual Life Insurance Company. Dr. Tzagournis is dean of the College of Medicine at the Ohio State University.

JOHN VERHOFF, M.D., Columbus, is president and **RONALD VAN BUREN, M.D.**, Columbus, is treasurer of the Ohio Academy of Family Physicians.

DONALD J. VINCENT, M.D., Columbus, and **ROBERT MURNANE, M.D.**, Upper Arlington, were selected by the department of medicine of the Ohio State University College of Medicine as recipients of the new Clinical Faculty Teaching Award.



Sylvan L. Weinberg, M.D.

SYLVAN LEE WEINBERG, M.D., Dayton, was elected president-elect of the American College of Chest Physicians. Dr. Weinberg is in the private practice of cardiology, and is clinical professor of medicine at Wright State University School of Medicine. He is the director of the coronary care unit at Good Samaritan Hospital and Health Center and also consulting physician to the Kettering Memorial Hospital and Sycamore Medical Center. Dr. Weinberg is chairman of the editorial advisory board of OSMA.

The following were elected officers of the Christ Hospital medical and dental staff in Cincinnati: **WALTER WILDMAN, M.D.**, president; **JOHN POTTSCHMIDT, M.D.**, vice-president; and **LOWELL GOLTER, M.D.**, secretary-treasurer.

RALPH WOLPAW, M.D., Cleveland, was presented with a certificate of appreciation naming him chief emeritus by the board of trustees of the Mt. Sinai Medical Center.

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Reflections on the Utilization of Health Care

By Richard J. Nowak, M.D.

In late September, 1982, it was my pleasure to represent the Ohio State Medical Association (OSMA) at a national conference on Utilization of Health Services, cosponsored by the American Medical Association (AMA), the American Hospital Association (AHA), and the Blue Cross and Blue Shield Plans.

Approximately 400 persons, including many physicians (about 20% of the attendees), were informed that the medical care environment will change dramatically in the latter part of this decade. Because of the continued rising costs of health care, more effective health services utilization review programs will be sought.

Several speakers at the conference cited examples of marked overutilization of medical services. Dr. Paul Gertman, Chief of Boston University School of Medicine Research Section, has developed an **Appropriateness Evaluation Protocol** over a five-year period, which has proved to be 95% accurate in evaluating inappropriate use of medical services. Dr. Gertman stated that one out of eight hospital admissions in northwest Massachusetts, where his study was conducted, was not medically

necessary and that one out of three days of hospital care was not necessary. Sometimes these situations were beyond control, such as unavailability of nursing home beds. His study also revealed that in some of the hospitals surveyed, one half of all utilization of services was unnecessary.

If prospective payment is managed by the government, what will happen to the quality of patient care?

The unnecessary utilization was defined as:

1. Overuse of nursing personnel resulting from excessive demands by physicians.
2. Overuse of tests for routine procedures. Example: Routine liver studies on every child having a tonsillectomy.
3. Overuse of medications, in some cases causing iatrogenic illnesses.

4. Overuse of services provided the terminally ill. Example: Every oncology patient was given a complete blood profile.

Undersecretary of the Department of Health and Human Services, David Swoap, reported on changes in hospital payment policies for Medicare patients from a cost-based reimbursement system to a prospective payment plan.

"The prospective system offers far more opportunities for cost control, rewarding efficiency and allowing providers to realize absolute savings and bonus payments for holding down their costs."

The development of such a hospital prospective payment plan, to be considered by the 1983 Congress, should stimulate more cost savings of medical care on a voluntary basis. If prospective payment is managed by the government, what will happen to the quality of patient care?

Representatives from labor and industrial management also expressed their concerns of the upward trend of health care costs, which are drastically affecting their ability to continue to provide top level health insurance programs as fringe benefits for their constituents.

continued on next page

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Richard J. Nowak, M.D.

"I believe the OSMA and its Cost Effectiveness Committee can contribute considerably to local efforts to achieve answers to problems . . . without impacting adversely on the high quality medical care that we are presently providing. . ."

**— Richard J. Nowak, M.D.
Cleveland, Ohio**

One labor representative, Kathy Schoen of the Service Employees International Union, said her union was forced to get into a program of utilization review for their union members because the rise in medical insurance premiums was becoming excessive. In 1975, the union experienced a 46% increase. The union established a self-administered trust fund to manage their health benefits program. Mandated second opinion surgery, preadmission testing, home health care delivery, and on-the-job hypertension screening were developed as additional benefits to their existing scope of benefits. To date, their entire premium increases for their members has not equaled the 46% increase experienced in 1975.

Another labor leader, Ed Toohey of the AFL-CIO (Philadelphia), stated his union members are instructed to inquire if the proposed medical

services actually are necessary, and if necessary, could the services be performed in a less expensive manner. His union is supporting less costly home care programs with the goal of keeping people out of the expensive hospital settings. Second opinions for elective surgery are also a requirement.

The chairman of the AMA Board of Trustees, Joe Boyle, M.D., who was also the conference moderator, emphasized that the medical care delivery system should be a community affair involving physicians, hospitals, consumers, employers, workers, insurance companies, and government officials, and that the challenges of costs and utilization of services can best be met on a voluntary basis rather than on a mandated or legislated basis.

James Sammons, M.D., AMA Executive Vice President, echoed his

colleague's opinion by stating that the best system to resolve our problem is the local, voluntary approach, and that the local coalitions being formed seem to offer the best opportunity to address and solve the problems of the 1980s.

I believe the OSMA and its Cost Effectiveness Committee can contribute considerably to local efforts to achieve answers to problems without impacting adversely on the high quality medical care that we are presently providing. Our Committee is presently studying several issues, namely, the aged population and the uninsured population.

At present one of the most pressing concerns is the number of Ohioans who have lost their health insurance benefits because of unemployment or reduction in eligibility for Medicaid or disability programs. It appears that any solution, whether by government

continued on next page

or otherwise, will be very long-term: but help must be started at the local and state levels.

A national committee has been formed by the AMA, AHA, Blue Cross-Blue Shield, AFL-CIO, Health Insurance Association and the Business Round Table to encourage communication between health care providers and the various publics (labor, consumers, management, etc.) to first identify the extent of the losses of health insurance coverage, and secondly, to formulate solutions. The committee is identified as the "Dunlop Committee," and will be providing guidelines to be used by local coalitions in formulating strategy to assist where loss of health coverage is prevalent. The OSMA Cost Effectiveness Committee will be in a position to evaluate the Dunlop proposals and start to analyze the results for use in Ohio.

The other pressing concern is the provision of health insurance for the aged population. Our Committee on

Cost Effectiveness has addressed this recently in concert with officials of the Ohio Medical Indemnity Mutual - Blue Shield. According to the Blues, the elderly (over 65) insured use more costly services than the under age 65

The real test of the voluntary health care system is for each physician to evaluate his/her own practice

insured. This directly impacts on the costs for the filler coverage the Blues underwrite to supplement costs not paid by Medicare. A great deal of statistical data has been analyzed, and the end result is that the over 65 population of services is higher. Several ideas were discussed. Among them were increased promotion of early discharge programs, alternatives

to inpatient treatment, ambulatory surgical care, and effective utilization review. Besides these economic considerations, there was great stress on quality of care issues.

I believe the real test of the voluntary system of health care delivery is for each physician to evaluate his or her own practice patterns with an eye toward questioning if each and every hospital admission or medical test is absolutely necessary, or if the same high quality of care could be obtained with less costly services.

When this kind of thinking becomes commonplace in the medical profession, then I believe we can achieve a high degree of success in the proper use of the resources entrusted to us and prove to our critics that the existing system of health care delivery is worthy of the public's trust.

Richard J. Nowak, M.D., Cleveland, is chairman of the OSMA's Cost Effectiveness Committee

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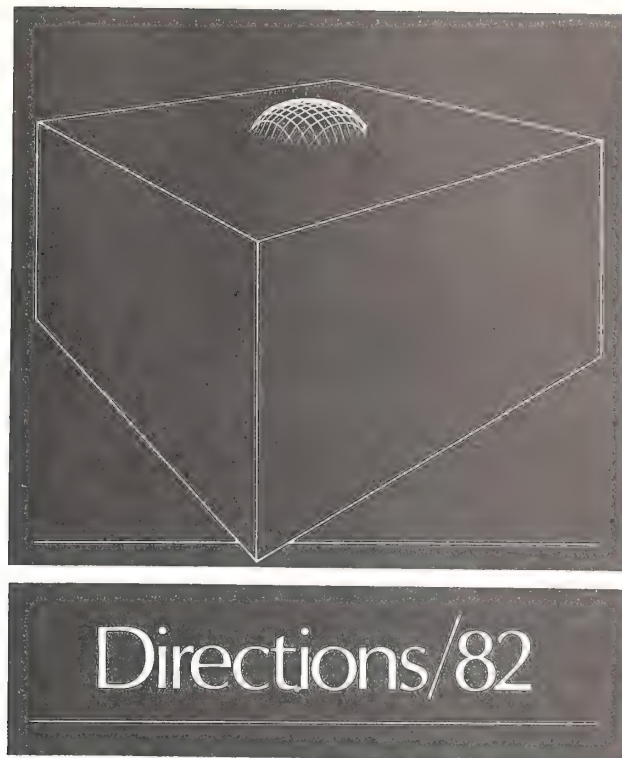
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

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Highlights of the OSMA Leadership Conference

By Karen S. Edwards and Gina DiBlasio Cummins

Competition. Politics. The aging population. Spiraling health care costs. . .

The list of issues facing medicine today is almost endless, and, like it or not, physicians are being thrust into roles outside the scope of their practice.

In order to help physicians not only understand these new roles, but to undertake a leadership position in them, the Ohio State Medical Association (OSMA) has initiated an annual Leadership Conference for its members.

"Directions '82," the first such conference, was held November 11-13, 1982, at the Marriott North Hotel in Columbus, Ohio. Nearly 100 members, representing some 30 counties, turned out to hear speakers address all of the topics mentioned above, plus others such as malpractice, media relations and medical/business coalitions.

Following is a pictorial look at the highlights of this year's conference. Watch future issues of the *Ohio State Medical Journal* for stories, based on topics presented at this Conference.

Thursday, The Preconference Seminars.



Ted Castele, M.D., Cleveland's TV doc (left) turns the microphone on William Dorner, M.D., Akron, Chairman of OSMA's Communications Committee. . .



Chris Solie, WNCI radio, Columbus, gives a definition of "news" in 2½ minutes: "Keep your statements simple, short," she advises.



Marcey Goulder, WBNS-TV, Columbus, urged physicians to "make yourselves available" to the media.



Rita Rubin, Columbus Citizen Journal: "Let your patients talk, too. They may be more willing than you think."

The OSMA Media/Speaker Training Seminar.

Marcey Goulder, WBNS-TV, Columbus, Chris Solie, WNCI radio, Columbus, and Rita Rubin, *Columbus Citizen Journal*, served as faculty members during the Media Training Seminar, held by OSMA's Department of Communications.

Attendees were briefed by the media representatives on what they could expect during an interview, and later were tipped by OSMA Communications Director, Rebecca Doll and Associate Director, Carol Wright Mullinax, on how to answer difficult questions. Then, with an assist from veteran television physician, Ted Castele, M.D., Cleveland (WEWS-TV), seminar participants had a chance to put their new-found information to work before the Department's television cameras.



Auxiliary Sharon Nelson, Columbus (Mrs. James H. Nelson III, M.D.), left, attended this seminar, as did Marilyn J. Huheey, M.D., Columbus, who has made a previous bid for a State Senate seat.



New Secretary of State, Sherrod Brown's father, Charles G. Brown, M.D., Mansfield, picks up some tips from the seminar.

Politics: The Driver's Seat.

As government becomes more involved in medicine, medicine is going to have to become more involved in politics. To help physicians assume leadership roles in this area, the OSMA's Department of Legislation held a preconference seminar on how to put you in the driver's seat in politics. Tips on how to conduct a political campaign, or simply how to become more involved in the legislative procedure were touched on in this seminar.

Competition: To Market, To Market.

One of the best attended seminars that day was on competition, and the marketing of physicians' services. Speakers included: Rebecca Bowman, Health Care Communications Consultant, Bell System; David W. Pennington, President, Physicians Administrative Corporation of Ohio (PACO); and Frank J. McDowney, Vice-President (PACO).



OSMA's Director of Field Service and Marketing, Bob Holcomb, addresses attendees at the Competition Seminar.

Friday. The Leadership Conference.



Leadership: Full Steam Ahead?

James P. Low, President of Dynamics, Inc., explained why physicians need to become involved in their local, state and national medical associations: "You work with your competitor to form a strong alliance, which, in turn, works toward improving the health care system in this country."



The Aging Population.

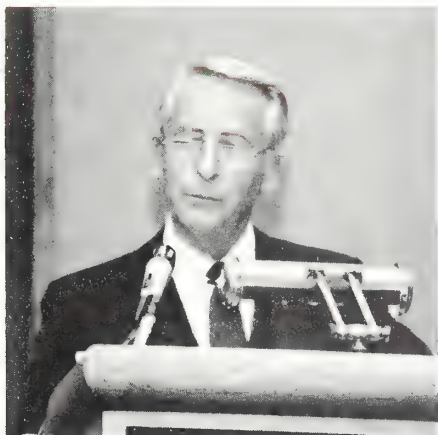
Robert H. Binstock, Ph.D., Director of the Policy Center on Aging at Brandeis University, discussed the "graying of America," and the medical and social problems involved with this issue: "Health care for the aged is going to shake up the system of delivery and financing of health care in this country."



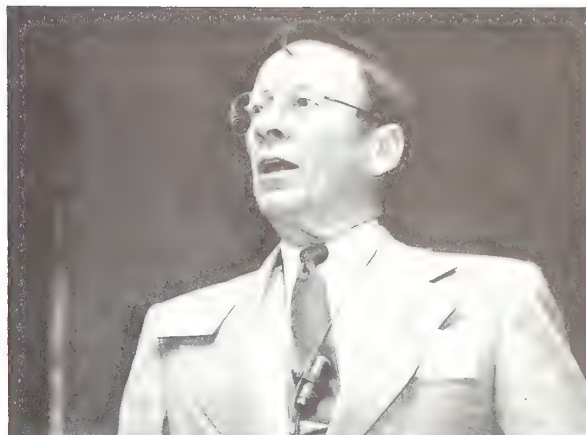
Health care . . . and the State Budget

Howard Collier, Director of the Ohio Office of Budget and Management, shared some insight into government's role in funding health care programs of the future: "Ohio's Medicaid payments are still not adequate, but Medicaid has become the largest dollar program in the State's health care budget."

Legislation: A New Course



John S. Zapp, D.D.S., Director of the AMA Washington office, along with OSMA's Legislative Director, D. Brent Mulgrew, J.D., analyzed the results of the recent election, and what it might mean to medicine: "Health Planning will be an issue again, and so will Medicare/Medicaid. The government is going to take another good, hard look at providers. . ."



AMA President William Y. Rial, M.D., Swarthmore, Pennsylvania, spoke out on the need to find a way to improve the efficiency of the medical system: "If you don't find ways to address the problems coming up in health care, then you can surely expect more bureaucracy in the future."

Breakout Sessions. The Banquet. Saturday Morning.

Four breakout sessions were available to the attendees: Investing; Medical Business Coalitions, with John J. Newton, M.D., Toledo and John Boyles, M.D., Dayton; Malpractice, with William M. Wells, M.D., Columbus, Chairman of the Board of PICO; and Physician/Hospital Relations, moderated by William Rial, M.D., and D. Brent Mulgrew, J.D.

Banquet speaker Dennis O'Leary, M.D., Washington, D.C., was the physician who "Calmed a Frightened Nation" in March, 1981, during the attempt on President Reagan's life. Dr. O'Leary spoke to Leadership attendees on the power of effective communications during such times of crisis.

Attendees took one last look down the road to health care on Saturday. Walter McClure, President of the

Center for Policy Studies, provided a probing look at the future: "Health care is in a severe market failure. We've ignored the economics in health care . . . now we're in trouble because government can't continue to ignore an inflationary industry — one that's the third largest in the country."

Ronald Berggren, M.D., Columbus, Chairman of OSMA's Task Force on Marketing and Competition, followed with a summary statement about what the OSMA is doing to help physicians in this area. He cited education, communication with business and industry, and research as tools being used by the Committee. "Most physicians went into medicine to treat patients," he said, "but we have learned that we must become familiar with the economic side of health care, too . . ."



OSMA Treasurer, David A. Barr, M.D., Lima, introduces William M. Wells, M.D., Columbus, at the Malpractice Breakout Session.

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*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythryl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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WARNINGS: The use of nitrates in acute myocardial infarction or congestive heart failure should be undertaken only under close clinical observation and / or in conjunction with hemodynamic monitoring.

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Medicine and Politics

The Annual Checkup

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgen deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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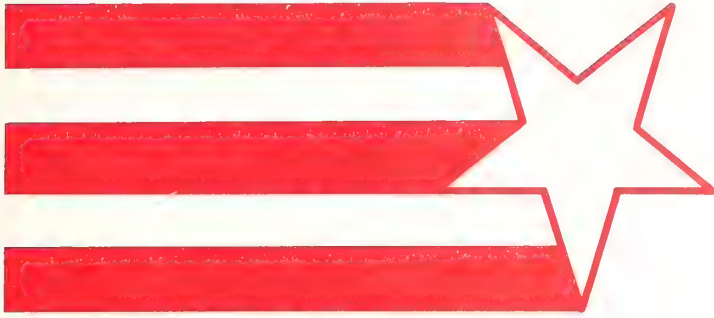
Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

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Election '82

Dawn of a Democratic Era

By Karen S. Edwards with the OSMA Legislative Staff

On Wednesday, November 3, 1982, Ohioans woke up to find they had given the Democrat Party its greatest election victory since 1958, when the Democrats swept all the statewide offices except Secretary of State.

While many may have been able to predict the change of the State's helm to Democratic gubernatorial candidate, Richard Celeste and his lieutenant-governor running mate, State Rep. Myrl Shoemaker (Celeste fell only 47,500 votes short of toppling Governor Rhodes from power four years ago), few were prepared for the totally clean sweep the Democrats made in all the statewide races:

- United States Senator Howard Metzenbaum won re-election to a new six-year term by beating Republican Paul Pfeifer 58% to 42%.

- Secretary of State Anthony J. Celebrezze, Jr. led the statewide ticket, receiving over 61% of the vote in his race for Attorney General against

Republican candidate Charles Saxbe.

- State Representative Sherrod Brown, son of Mansfield physician Charles Brown, won his race for Secretary of State against Republican Virgil Brown.

- Marion County Treasurer Mary Ellen Withrow emerged victorious in her race for state treasurer against Republican candidate Dana Rhinehart and Libertarian candidate Thomas Brown.

- State Auditor Thomas Ferguson was re-elected to a third term, defeating Republican Vincent Campenella.

- In a series of hard-fought campaigns for control of the Ohio Senate, the Democrats turned an 18-15 Republican advantage into a 17-16 Democrat majority. However, in early December, State Senator Morris Jackson (D-Cleveland) announced he would be elected Senate president by the 16 Republican members. If the

agreement holds, Senator Jackson will be the President, but the leadership and major committee chairmen will be Republicans. At this writing, the Democratic leadership is attempting to convince Senator Jackson to go back on his arrangement.

- In the House of Representatives, Democrats increased their numbers by beating seven Republican incumbents while losing only one seat for a net gain of six seats, giving them a 62-37 majority. Democrat incumbent, Rep. Kevin Kapel of Chesterland, lost in his attempt to retain control of the seat to which he was appointed.

This election marks the first time since 1958, that the Democrats have been in such complete control of state government and the first time since 1970, that the same party will control both the governor's office and both houses of the General Assembly.

What does all this mean for medicine?

Election '82

Dawn of a Democratic Era

"Organized medicine's issues are nonpartisan and the OSMA's bipartisan political support reflects that," said Brent Mulgrew, J.D., Associate Executive Director of the OSMA, and Director of its Department of Legislation.

Speaking at the recent OSMA Leadership Conference, Mulgrew was quick to praise those physician members and members of the OSMA

Auxiliary, who have involved themselves with both local and state politics.

"Without this support at the grass roots level, OSMA couldn't be doing its job politically," he says. "Your legislative representatives in Columbus and Washington cannot continue to be successful without aggressive back home, grass roots work by OSMA members and Auxilians," Mulgrew

added, "and that means a willingness to get involved in the legislative process.

With over 30 new members joining the General Assembly in January 1982, now more than ever, physicians and Auxilians must be willing to get involved."

Following is the election results for the Ohio House, the Ohio Senate and the U.S. Congress: (winners are listed first, * denotes incumbent).

Ohio Senate Races

DISTRICT #1

M. Ben Gaeth, Republican*

DISTRICT #3

Theodore M. Gray, Republican*

DISTRICT #5

Neal F. Zimmers, Jr., Democrat*

DISTRICT #7

Richard H. Finan, Republican*

DISTRICT #9

William F. Bowen, Democrat*

DISTRICT #11

Marigene Valiquette, Democrat*

DISTRICT #13

Alan J. Zaleski, Democrat

DISTRICT #15

Richard C. Pfeiffer, Jr., Democrat

DISTRICT #17

Oakley C. Collins, Republican*

DISTRICT #19

Lowell Steinbrenner, Republican

DISTRICT #21

M. Morris Jackson, Democrat*

DISTRICT #23

Charles L. Butts, Democrat*

DISTRICT #25

Lee I. Fisher, Democrat

DISTRICT #27

Oliver Ocasek, Democrat*

DISTRICT #29

Thomas F. Walsh, Republican*

DISTRICT #31

Eugene Branstool, Democrat

DISTRICT #33

Harry Meshel, Democrat*

DISTRICT #4

William G. Batchelder, Republican*

DISTRICT #5

Robert E. Brown, Republican*

DISTRICT #6

James M. Petro, Republican*
(uncontested)

DISTRICT #7

Rocco J. Colonna, Democrat*

DISTRICT #8

Francine M. Panehal, Democrat*

DISTRICT #9

Patrick A. Sweeney, Democrat*

DISTRICT #10

June April Kreuzer, Democrat

DISTRICT #11

Barbara Pringle, Democrat

DISTRICT #12

Troy Lee James, Democrat*

DISTRICT #13

Frank Mahnic, Jr., Democrat*

Ohio House Races

DISTRICT #1

Waldo Bennett Rose, Republican*

DISTRICT #2

Robert J. Boggs, Democrat*

DISTRICT #3

John D. Shivers, Jr., Democrat

DISTRICT #14

Ike Thompson, Democrat*

DISTRICT #29

Ray Miller, Democrat*

DISTRICT #44

Thomas C. Sawyer, Democrat*

DISTRICT #15

Mary O. Boyle, Democrat*

DISTRICT #30

Mike Stinziano, Democrat*

DISTRICT #45

Casey C. Jones, Democrat*

DISTRICT #16

John D. Thompson, Jr., Democrat*

DISTRICT #31

Otto Beatty, Jr., Democrat*

DISTRICT #46

Arthur R. Wilkowski, Democrat*

DISTRICT #17

LeRoy D. Peterson, Democrat

DISTRICT #32

Dean Conley, Democrat*

DISTRICT #47

Barney Quilter, Democrat*

DISTRICT #18

Judy B. Sheerer, Democrat

DISTRICT #33

Don E. Gilmore, Republican*

DISTRICT #48

John A. Galbraith, Republican*

DISTRICT #19

Ronald J. Suster, Democrat*

DISTRICT #34

JoAnn Davidson, Republican*

DISTRICT #49

Charles Red Ash, Republican*

DISTRICT #20

Thomas A. Pottenger, Republican*

DISTRICT #35

Dana A. Deshler, Jr., Republican*

DISTRICT #50

William J. Healy, Democrat*

DISTRICT #21

Jerome F. Luebbers, Democrat*

DISTRICT #36

C. J. McLin, Jr., Democrat*

DISTRICT #51

Dave Johnson, Republican*

DISTRICT #22

Louis W. Blessing, Jr., Republican

DISTRICT #37

Edward J. Orlett, Democrat*

DISTRICT #52

Joseph J. Vukovich III, Democrat*

DISTRICT #23

William L. Mallory, Democrat*

DISTRICT #38

Robert L. Corbin, Republican*

DISTRICT #53

Thomas P. Gilmartin, Democrat*

DISTRICT #24

Terry M. Tranter, Democrat*

DISTRICT #39

Robert E. Hickey, Democrat

DISTRICT #54

John V. Bara, Democrat

DISTRICT #25

Helen Rankin, Democrat*

DISTRICT #40

Russ Guerra, Jr., Republican*

DISTRICT #55

Michael J. Camera, Democrat

DISTRICT #26

John O'Brien, Republican*

DISTRICT #41

Robert D. Nettle, Democrat*

DISTRICT #56

Michael A. Fox, Republican*

DISTRICT #27

Dale N. Van Vyven, Republican*

DISTRICT #42

Pete Crossland, Democrat*

DISTRICT #57

William W. Donham, Republican*

DISTRICT #28

David J. Leland, Democrat

DISTRICT #43

Vernon F. Cook, Democrat*

DISTRICT #58

Joseph P. Williams, Democrat*

DISTRICT #59

Michael G. Verich, Democrat

DISTRICT #60

Daniel P. Troy, Democrat

DISTRICT #61

Robert E. Hagan, Democrat

DISTRICT #62

David Hartley, Democrat*

DISTRICT #63

Paul Jones, Democrat

DISTRICT #64

Frank S. Sawyer, Democrat

DISTRICT #65

Robert H. Doyle, Republican

DISTRICT #66

Sue J. Fisher, Republican

DISTRICT #67

Marc D. Guthrie, Democrat

DISTRICT #68

Robert E. Netzley, Republican*

DISTRICT #69

Cliff Skeen, Democrat*

DISTRICT #70

Fredrick H. Deering, Democrat*

DISTRICT #71

Ronald V. Gerberry, Democrat*

DISTRICT #72

Marie Tansey, Republican*

DISTRICT #73

Jim Buchy, Republican

DISTRICT #74

Robert W. Clark, Republican

DISTRICT #75

Joseph E. Haines, Republican*

DISTRICT #76

Harry E. Turner, Republican*

DISTRICT #77

Harry C. Malott, Democrat*

DISTRICT #78

Steven O. Williams, Republican*

DISTRICT #79

Larry W. Manahan, Republican*

DISTRICT #80

Charles R. Earl, Republican*

DISTRICT #81

Dale L. Locker, Democrat*

DISTRICT #82

John P. Stozich, Republican

DISTRICT #83

Rod Hughes, Republican*

DISTRICT #84

Corwin M. Nixon, Republican*

DISTRICT #85

Dwight Wise, Jr., Democrat

DISTRICT #86

Walter D. McClaskey, Republican*

DISTRICT #87

Joan W. Lawrence, Republican

DISTRICT #88

Michael C. Shoemaker, Democrat

DISTRICT #89Vernal G. Riffe, Jr., Democrat*
(uncontested)**DISTRICT #90**

Richard E. Rench, Republican

DISTRICT #91

Paul P. Mechling, Democrat

DISTRICT #92

Ronald H. James, Democrat*

DISTRICT #93

Ron Amstutz, Republican*

DISTRICT #94

Jolynn Boster, Democrat

DISTRICT #95

Joe Secrest, Democrat

DISTRICT #96

Tom Johnson, Republican*

DISTRICT #97

William E. Hinig, Democrat*

DISTRICT #98

Arthur R. Bowers, Democrat*

DISTRICT #99

Jack Cera, Democrat

U.S. Congress Races

DISTRICT #1

Thomas A. Luken, Democrat*

DISTRICT #2

Willis D. Gradison, Jr., Republican*

DISTRICT #3

Tony P. Hall, Democrat*

DISTRICT #4

Michael G. Oxley, Republican*

DISTRICT #5

Delbert L. Latta, Republican*

DISTRICT #12

John R. Kasich, Republican

DISTRICT #19

Edward F. Feighan, Democrat

DISTRICT #6

Bob McEwen, Republican*

DISTRICT #13

Donald J. Pease, Democrat*

DISTRICT #20

Mary Rose Oakar, Democrat*

DISTRICT #7

Michael DeWine, Republican

DISTRICT #14

John F. Seiberling, Democrat*

DISTRICT #21

Louis Stokes, Democrat*

DISTRICT #8

Thomas N. Kindness, Republican*

DISTRICT #15

Chalmers P. Wylie, Republican*

*Karen S. Edwards is the Executive Editor
of the Ohio State Medical Journal***DISTRICT #9**

Marcy Kaptur, Democrat

DISTRICT #16

Ralph Regula, Republican*

DISTRICT #10

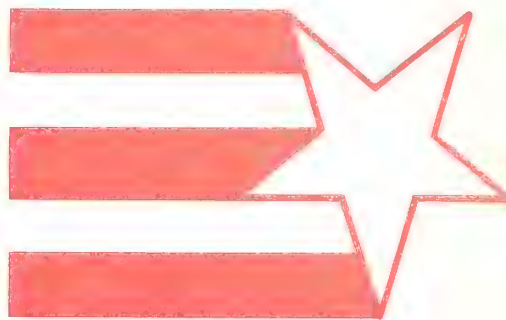
Clarence E. Miller, Republican*

DISTRICT #17

Lyle Williams, Republican*

DISTRICT #11

Dennis E. Eckart, Democrat*

DISTRICT #18Douglas Applegate, Democrat*
(uncontested)

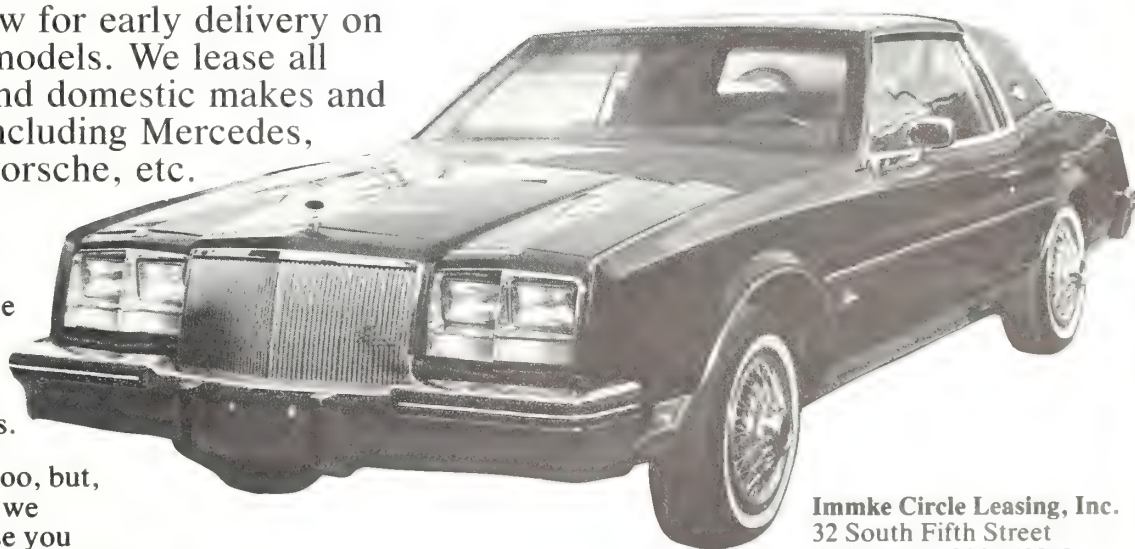
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1982 Health Care Legislation

It Was a Very Good Year

By Karen S. Edwards with the OSMA Legislative Staff

The 114th Ohio General Assembly handled a mixed bag of health-care legislation during the 1981-1982 biennium — a session which proved to be highly successful for the Ohio State Medical Association's (OSMA) Department of Legislation.

Listed below are the most notable victories accomplished by the OSMA, along with some background on the bills, and what their passage (or defeat) means to you:

HOSPITAL LICENSURE (HOUSE BILL 173)

Background: This legislation is actually a redraft, somewhat modified, of last session's HB 753 to license Ohio's hospitals, which passed the House, but did not come out of the Senate. The psychologists and other groups lobbied heavily on that bill for admitting privileges, and were stopped in their efforts, twice, by the OSMA.

What it says: This new law requires that all hospitals meet certain minimum standards of operation. A hospital would have two routes to compliance: accreditation by the Joint Commission for the Accreditation of Hospitals or the American Osteopathic

Association, or certification by Medicare. The health department would be authorized to investigate evidence which indicates hospital deficiencies endangering public health or safety. The law also states that patients must be admitted by physicians (M.D. or D.O.) and dentists, or coadmitted by podiatrists, and must be under the medical supervision of physicians.

What it means to you: One important aspect of this new law is its recognition of the hospital as a medical facility for treatment of acute and chronic illnesses. As under Medicare and JCAH, the bill requires patients to be admitted by medical practitioners and under the care of a physician. These standards have tremendous implications to hospital efforts in cost containment, utilization review and quality assurance. Despite an aggressive lobbying effort by psychologists, chiropractors and midwives, hospital admission will remain, under law, in the hands of physicians.

STATE MEDICAL BOARD BILL (HOUSE BILL 317)

Background: A complicated legislative battle on this issue was

waged for nearly three years before this bill was signed into law. Its roots belong to a bill, introduced into the Senate (SB 368) during 1980. The bill, which sought to increase the funding, staff and investigative powers of the Board, passed the Senate unanimously, but died on the House floor in the last days of the 113th General Assembly. The failure of that bill came as the result of lobbying by a loose coalition of nonmedical groups which misrepresented the intent and language of the bill. Similar misinformation was disseminated on HB 317 when it was introduced in 1981. The bill, which again sought to increase the investigative and disciplinary authority of the Board, met with an organized effort to discredit medicine through propaganda and media scare tactics.

With regard to the bill, the OSMA sought two goals: (1) to protect the public from unethical and incompetent practitioners through an effective State Medical Board, and (2) to protect practitioners from harassment and invasion of privacy by structuring Medical Board procedures so that due process rights are protected.

What it says: New authority is now granted to the Medical Board in both its investigative and disciplinary powers. However, the investigative subpoena power of the Board is

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restricted by requiring the written consent of a patient before his or her medical records can be subpoenaed, except in drug offense cases. Also, the types of cases where the investigative subpoena can be used are limited to drug cases, fraud cases, cases involving a felony conviction and cases where there is a violation of the limited licensure statutes.

What it means to you: While the investigative and disciplinary powers of the Board have been increased, physicians have also been better assured their right to due process during a State Board investigation.

DETERMINATION OF DEATH (SENATE BILL 98)

Background: OSMA's support of this legislation was the result of a 1980 House of Delegates resolution directing the Association to actively support legislation based on the Model Uniform Determination of Death Act. With the passage of this bill into law, Ohio joins the ranks of 29 other states which have adopted language, adding lack of brain functions to the legal basis for determination of death.

What it says: The new law states that an individual shall be considered dead if he has sustained either "irreversible cessation of respiratory and circulatory functions of the brain, including the brain stem, as determined in accordance with acceptable medical standards."

What it means to you: Establishes new criteria for the legal determination of death.

REPEAL OF A MANDATORY PREMARITAL SEROLOGY FOR SYPHILIS; REPEAL OF HEALTH SYSTEMS AGENCIES; AUTHORIZATION OF CERTIFICATION BY SIGNATURE FOR REPORTING CME HOURS TO THE STATE MEDICAL BOARD. (AMENDMENTS TO HOUSE BILL 694)

Background: OSMA's support for the repeal of premarital syphilis testing was, again, pursuant to a House of Delegates directive (1981), and came with the strong support of the Ohio Department of Health.

The Department of Health, as well as other groups, also lobbied with the OSMA to eliminate individual Health Systems Agencies from continuing to operate in Ohio.

Both of these measures, as well as a third amendment authorizing signatures for reporting continuing education credit hours to the State Medical Board, were accomplished through amendments to the State Budget.

What it says: Premarital serology testing for syphilis, formerly required under Ohio law, is no longer necessary.

As far as the individual Health Systems Agencies are concerned, they have continued in operation until contracts with the Federal Department of Health and Human Services expire. Health planning activities are now centralized in the Ohio Department of Health.

The need for physicians to mail CME log books to the State Medical Board for license re-registration has been eliminated, although they must certify by signature that the requisite hours have been fulfilled. Physicians should retain their CME documentation, however, as the State Medical Board retains authority to audit CME records.

What it means to you: In light of health care's continuously spiraling costs, the above-mentioned repeals attest to Ohio physicians' sincere and voluntary efforts to keep down the costs of health care.

OMNIBUS DRUNK DRIVING LEGISLATION (SENATE BILL 432)

Background: A resolution, passed by the House of Delegates at the 1982 Annual Meeting, supported the concept of this bill, and OSMA's

concern to legislatively address the serious problem of drunk driving.

What it says: This legislation approaches the drunk driving problem from various aspects. It increases penalties for driving while intoxicated (DWI) or driving while under the influence of drugs, including mandatory jail time and lengthy license revocations. Persons driving with a suspended license could receive an additional year's suspension. Drivers convicted of vehicular homicide involving DWI would lose their license permanently. The bill also would establish new procedures to suspend the license of anyone testing over a 0.10 alcohol level.

What it means to you: Emphasis is placed on driver education and rehabilitation in this bill. Fees charged for license reinstatement would support programs designed to identify and assist the alcoholic driver.

CHILD SAFETY SEAT RESTRAINT (HOUSE BILL 605)

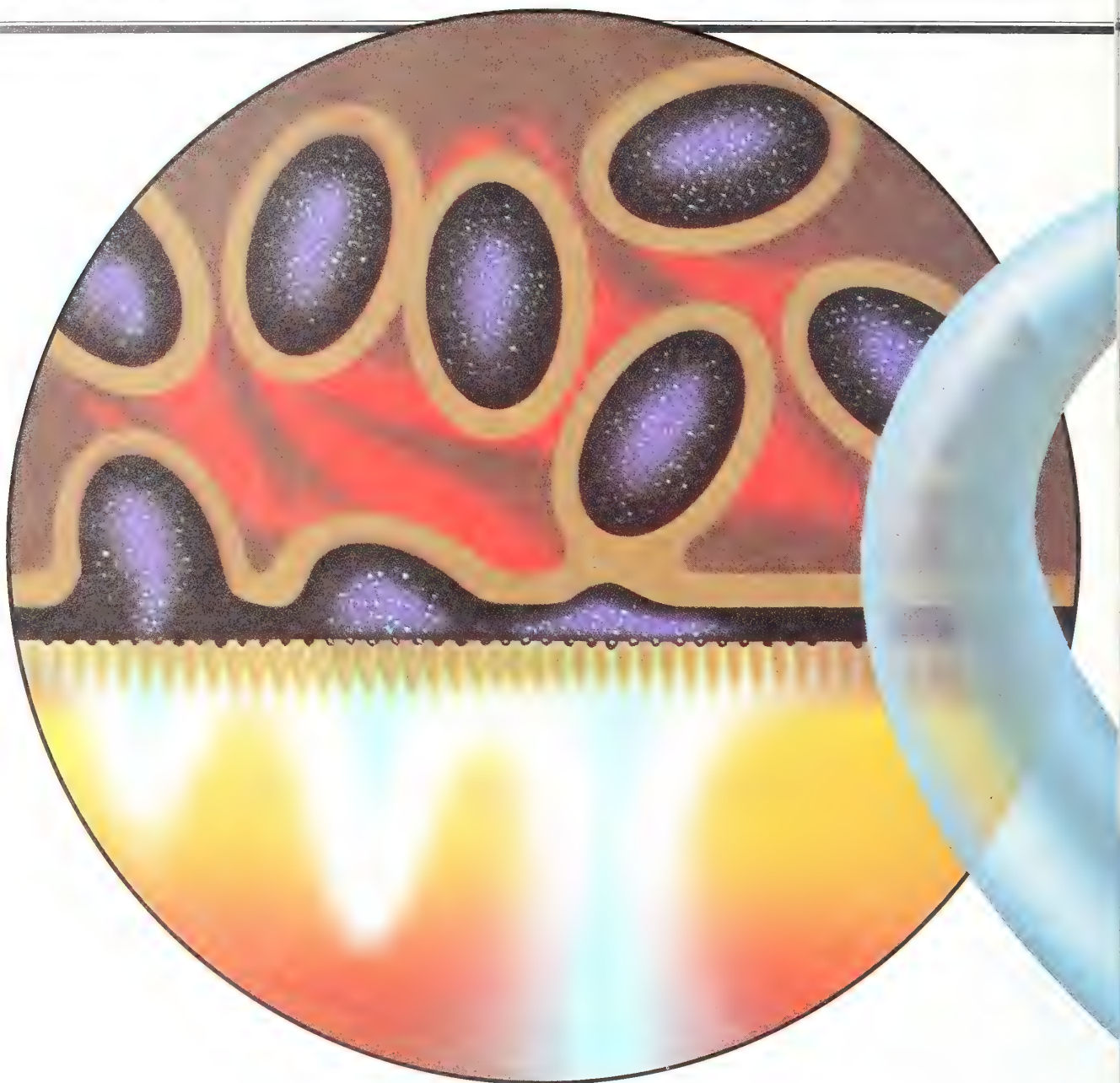
Background: Although a similar measure died on the House floor last session, the facts are still there. Automobile accidents are the leading cause of childhood death and injury; evidence indicates that safety restraints could reduce injuries by up to 70% and deaths by up to 90%.

What it says: The new law mandates safety seat restraints for infants who are less than four years old or weigh less than 40 pounds. If the child is being transported in a car, then the following precautions must be taken: (1) for children under one year old, the child must be in a safety restraint system; (2) for children from one to four years old, either a child restraint system or a seat belt must be used. The law would not apply when the child is transported in a taxi or bus.

The penalty for violations of HB 605 would be a \$10 fine. The fine would be waived if a safety restraint system is purchased or rented by the time of the court date.

continued on page 38

VALIUM[®] (diazepam/Roche) IN THE FOREFRONT OF NEURORECEPTOR RESEARCH



Artist's concept of neurotransmitter
being released into synaptic cleft and
impinging on receptor sites



Opening new investigative pathways into where and how Valium (diazepam/Roche) exerts its distinctive antianxiety action

New discoveries in receptor research have stimulated the search for endogenous brain substances that may be involved in the mediation of anxiety.¹⁻⁵ It has been further theorized that these substances may act as ligands that bind to the same or similar sites as do benzodiazepine molecules^{5,6}—binding sites early identified with the use of ³H-diazepam.^{5,7} These binding sites are now postulated to be benzodiazepine receptors, since the ability of benzodiazepines to bind with the sites appears to correlate with their clinical effects.^{2,4,7,8}

Present investigations into clinical relevance of binding sites.

Laboratories at Roche have conducted research to identify and isolate substances that may prove to be endogenous ligands, but no definitive identification has yet been made. Researchers are also studying substances which do not bind, but rather interact with the benzodiazepine binding sites—most notably gamma-aminobutyric acid (GABA)—and are postulated to mediate certain pharmacologic and clinical benzodiazepine effects.^{2-4,9,10}

Under especially intense investigations are the GABA receptors and the benzodiazepine binding sites themselves—apparently constellations of closely linked but not identical structures.⁸

Future implications for improved therapy.

In future work, Roche researchers and other scientists hope to identify and characterize various differential sites in the brain, which may result in more specific diagnostic and therapeutic approaches.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not as sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500; * Prescription Paks of 50, available in trays of 10; * Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25¹ and in boxes containing 10 strips of 10.¹

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701

¹Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

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1982 Health Care Legislation: A Very Good Year

(continued)

What it means to you: OSMA's strong support of this legislation exemplified the medical profession's determination to reduce the number of infant fatalities resulting from traffic accidents.

The OSMA's Department of Legislation can list other accomplishments as well:

Amended HB 51 enacted to grant immunity to any person who, without malice, supplies information to hospital utilization review, peer review and credentialing committees, or medical society peer review committees.

Worked for enactment of HB 135, which requires identification of drugs in solid dosage forms.

Worked with psychiatrists within OSMA membership, for SB 336, outpatient benefits for alcoholism and mental health.

Stalled HB 820, which would mandate participation by psychologists, optometrists, podiatrists and chiropractors in HMOs or IPAs.

Lobbied to defeat SB 97, which would exempt certain teaching physicians from the FLEX exam for medical licensure in this state.

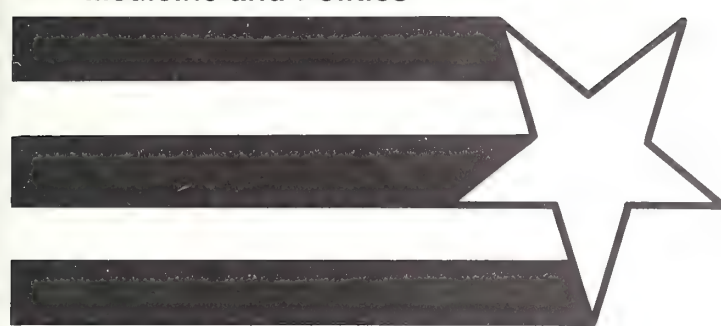
EXEMPTION FROM STATE PHARMACY BOARD LICENSURE (SENATE BILL 4)

Background: For years, the OSMA has disputed a statutory interpretation of the Ohio State Board of Pharmacy under which the Board has required certain physicians to obtain licensure as "terminal distributors of dangerous drugs." The Dangerous Drugs Law of Ohio specifically *exempts* physicians from the requirement for licensure as terminal distributors of dangerous drugs. However, the Pharmacy Board interpreted the statute to require licensure for physician professional corporations. The OSMA sought to exempt professional corporations and partnerships from terminal distributor licenses by amending a measure that would permit an emergency medical service system to obtain one

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Medicine's Legislative Future

By Karen S. Edwards with the OSMA Legislative Staff

The future has never been easy to predict. That's why projecting the health care legislation that will come out of the 1983 State Legislature is difficult, at best, and complicated by the fact that the make-up of the 115th General Assembly will be markedly different from that of its predecessor.

Regardless, there are certain issues which the OSMA Department of Legislation feels will inevitably be placed before the state legislature next year.

"Some will be the same or similar issues," says Eric Burkland, OSMA's Director of State Legislation, "but there are new ideas coming out of Washington with which the State Legislature is going to have to deal and a changing health care marketplace with which we will all have to come to grips."

The federal government's move to increase the state role in government, administratively as well as financially, already has made an impact on the Statehouse.

Listed below are some of the areas which the Department of Legislation

think will receive legislation attention this year. Each is followed by a brief explanation.

MEDICAID

The Medicaid program, itself, is experiencing a fiscal crisis with increasing costs and decreasing revenues. Since federal mandates for the program have loosened, many states are restructuring their Medicaid programs in an attempt to hold down revenue outlays. Inevitably, then, the proposals for program redesign will be at issue next session. . .

One aspect of this issue, physician reimbursement, already has received physician involvement.

In testimony before the Joint Committee on Physician Reimbursement for Medicaid, S. Baird Pfahl, M.D., Sandusky, and President-Elect of the OSMA said: "The OSMA strongly believes that the Medicaid program must not be allowed to drift away from its original and fundamental objective: to provide the

nation's poor with access to high-quality mainstream medical care. (However). . .the low fee schedule inevitably discourages physician participation and lowers access to mainstream medical care."

Dr. Pfahl added, in closing, that the physicians of Ohio are both ready and willing to work with the State on the issue of Medicaid reform.

"If changes are to be made," he said, "we would urge that the State incorporate a fee-for-service reimbursement approach into a system of workable cost controls."

And this is the direction in which the OSMA Department of Legislation is moving.

MALPRACTICE

Legislation concerning the Joint Underwriting Authority (JUA) and the Stabilization Reserve Fund (SRF) has been under negotiation for some months.

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Burkland says. Because the recent malpractice experience of medicine in other states seems to indicate that a problem of price — if not availability — is a potential threat, there is also a legislative move to keep both the JUA and the SRF in statute in the event that they are needed in some form in the future.

"The entire malpractice environment is under examination, including expanding the physician's right to countersue in malpractice suits," Burkland says.

CATASTROPHIC HEALTH INSURANCE

Unlike a number of other states, the State of Ohio has no state-backed "catastrophic health insurance" on the books — yet an increasing number of requests for financial assistance to meet catastrophic health costs have been made to the Governor and the State Controlling Board.

"The State Controlling Board has asked the legislature for some guidance on how to respond to these individual requests for financial assistance to pay large medical bills," Burkland says.

It seems likely, then, that this issue will come up for discussion in the 115th General Assembly.

ALLIED HEALTH FIELDS

Undaunted by previous defeats in the State Legislature, the allied health professionals will be seeking, once again, to expand their scope of practice.

"Ohio optometrists again will introduce legislation, permitting optometric use of diagnostic drugs," Burkland says.

Physical therapists are discussing legislation which would permit physical therapists to establish professional corporations, and mechanotherapists/massotherapists are pressing for the establishment of separate professional boards.

DRUG ABUSE, MISUSE, AND DIVERSION

This topic has become a major issue at the federal, state and local levels. The American Medical Association is working with other groups to develop model procedures and guidelines to counter misuse of prescription drugs. The illegal diversion of prescription drugs by practitioners is an issue that must be addressed.

"The State Legislature realizes that there is a problem out there in this area and they are concerned," says Michael Bateson, Assistant Director, State Legislation.

Certain groups already are requesting that certain drugs, like Quaaludes and amphetamines, be eliminated from the market.

The entire issue of drug abuse is certainly one which will be addressed by the new Assembly, and so will necessarily be of concern to the OSMA.

EMERGENCY MEDICAL SYSTEMS

Several efforts are underway with regard to emergency medical systems, including the standardization and upgrading of services, equipment and personnel. The OSMA is working with the American College of Emergency Physicians in this area.

HEALTH PLANNING/CON

Health systems agencies in Ohio already are being phased out, fusing into a single health planning mechanism, centralized in the Ohio Department of Health. Since health planning is in limbo at the federal level, however, the future of the state program is equally uncertain.

Other health care areas are bound to be addressed in the new year — abortion, living wills, nursing, temporary medical certificates, medical records, etc. The OSMA's Department of Legislation will continue to monitor the 115th General Assembly and watch for those issues which will affect you and the practice of medicine.

The people who make it all happen . . .

The OSMA's Committee on State Legislation is made up of the following members:

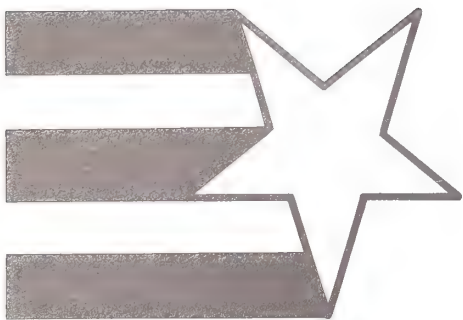
Chairman: Benjamin H. Reed, M.D., Delta

J. James Anderson, M.D., Youngstown
Fred D. Barton, M.D., Akron
Larry Bishop (student), Fairborn
John H. Boyles, Jr., M.D., Dayton
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William L. Sovik, M.D., Poland
Mrs. Rose Vesper, New Richmond
Mrs. Valerie Vollmer, Newark
Robert S. Young, M.D., Johnstown



The OSMA's Department of Legislation is made up of the following members: D. Brent Mulgrew, J.D., Associate Executive Director, OSMA, Director, Department of Federal and State Legislation; Eric L. Burkland, Associate Director, State Legislation; Michael L. Bateson, Assistant Director, State Legislation; Catherine M. Costello, J.D., Assistant Director, State Legislation; and Aristotle L. Hutras, Assistant Director, State Legislation.

The department's administrative responsibilities are organized and coordinated by Phyllis Fisher and Judy Gerken.



And then there are rules

By Karen S. Edwards

While the Legislature mulls over the hundreds of bills introduced each session, the state-created agencies which exist in Ohio are involved in their own paper chase.

These agencies, which have been delegated certain authority under state law, are busy promulgating "rules" — new regulations for those groups or individuals which fall under their jurisdiction. How busy? Estimates, given by Ms. Carolyn Towner, Executive Director of the Joint Committee on Agency Rule Review (JCARR), the legislative committee which reviews agency rules, indicates that nearly 3,000 rules were filed with the JCARR during 1982 — "and we've handled about 12,000 rules since 1978," she says.

"In the past five years, agencies have acted more aggressively to clarify their responsibilities and procedures through the rule-making process," says Catherine M. Costello, J.D., Assistant Director, State Legislation.

The OSMA's concern, however, is that some agencies are using their rule-making power substantively — in other words, using the rules to expand the scope of the agency's authority beyond what was intended by the Legislature. "If an agency or board seeks to expand its power, the authority to do so should come from a statute passed by the Legislature, and not from the agency through the rule-making process," Costello says.

How then, does one go about challenging a rule proposed by an agency — for example, one proposed last year by the Chiropractic Board which would expand a chiropractor's scope of practice? Apparently, it's not all that easy.

Once an agency has written its proposed rule, it must be filed with the Secretary of State and the Legislature. With most rules, if no changes are made to the rule, in 60 days it can be adopted by the agency in its final form.

"But there are accesses into the system," Costello explains.

During the 60-day waiting period, the agency must hold a public hearing on its proposed rule. "In Ohio, this is known as a Chapter 119 hearing — the agency is required to make a written record of the hearing," Costello says. The agency has the option of considering any testimony given and making changes in the rule.

Agencies have become more aggressive in clarifying their responsibilities through the rule-making process.

"In the case of a controversial rule, the agency may choose to withdraw it or to redraft it based upon the comments received," Costello says.

Besides the public hearing, the rule goes to the aforementioned JCARR for its consideration. The JCARR, a bipartisan committee made up of five members of the House and five members of the Senate, oversees the agencies' rules. If the JCARR recommends invalidation of the rule, and both the Senate and the House

vote to invalidate, the rule can't be proposed again during the present legislative session.

"Most agencies would rather withdraw a rule than lose their ability to refile it for the rest of the session — maybe as long as two years," Costello says. The chiropractic rule was withdrawn before the JCARR could recommend invalidation.

"Although the JCARR has authority to recommend the invalidation of a rule, this is only a limited power. A vote to invalidate can occur only if the rule fails to meet one of three criteria," says Costello.

The proposed rule must: (1) fall within the scope of the agency's authority; (2) it must be consistent with the intent of the statute to which the rule refers; and (3) it cannot conflict with other existing rules.

"Only if the rule fails to meet one of these criteria can the Legislature, upon recommendation of the JCARR, step in and veto it. Otherwise, on the 61st day, it becomes a new regulation," Costello says.

That's why it has become crucial for the OSMA to monitor the proposed regulations at the agency level, for once a rule has been promulgated, it is just as binding in its effect as a statute. "The only way to fight it (after 61 days) is in the courts," Costello says.

That's why the OSMA's Department of State Legislation keeps as careful a watch over the agency rules as it does over the Legislature.

"It seems to be a legislative avenue of the future," Costello says, "so we'll continue to monitor it." **OSMA**

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal



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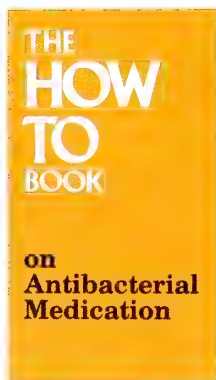
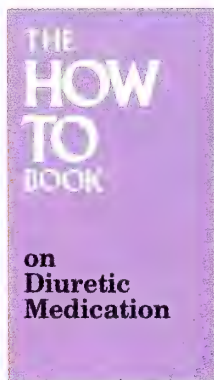
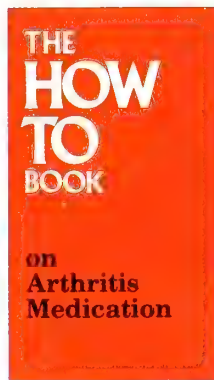
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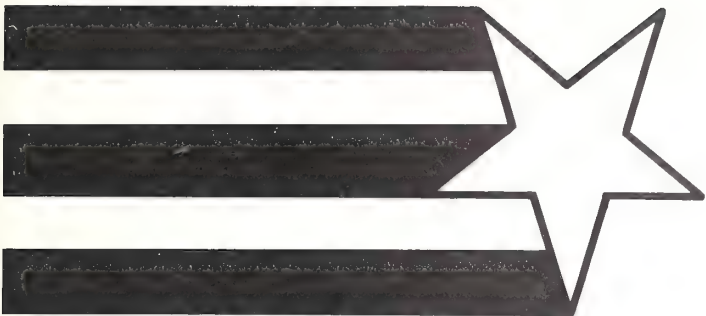
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The Personal Touch

By Gina DiBlasio Cummins

Leave it to the OSMA Auxiliary to show that when there's a need — there's a way.

When they recognized a need in Ohio for better, more effective communications with legislators, the auxiliary met the challenge head-on. They created the Medical Resource Person (MRP) program, a statewide network of physicians' spouses, formed to establish a good rapport with local legislators. Conceived by Rose Vesper, 1982-1983 President of the OSMA Auxiliary, this three-year-old program has grown to 200 volunteers. The program is coordinated by Valerie Vollmer, Newark, Auxiliary Legislative Chairman.

"This program encompasses and builds on the AMA Auxiliary's Legislative Alert system. In some ways it's comparable to the AMA's Key Physician program but with the emphasis on what we can do for our legislators rather than what they can do for us."

She explains that the program has the theme "friendships with a purpose." "We realize that it's easier for a legislator to communicate with a friend than with an acquaintance or a constituent who is just a signature at the end of a letter. If the legislator knows this friend is an intelligent, credible individual, his or her mind

will be more receptive to what this friend has to say."

The main thrust of what these resource people have to say and do is mainly this — to provide legislators with accurate information on the far-reaching implications of proposed solutions to health care needs. In addition, as consumer advocates for receivers of medical care, they work to improve the quality and availability of health care.

The MRP does not initiate the action, but wholeheartedly supports the actions of the OSMA legislative

"We realize it's easier for a legislator to communicate with a friend than a signature at the end of a letter."

staff. "Resource people contact their legislator regarding medical bills only at the request of the OSMA."

Since over half of state and federal legislators are covered by the MRP program — 200 auxiliarians cover 85 state and federal legislators — that unified action can have a dramatic impact.

Last March a hospital licensure bill

came out of committee and before the house in just three days, a process which normally takes weeks.

Determined to defeat a proposed amendment which would grant psychologists authority to admit patients to hospitals, the OSMA turned to their Key Physicians and Medical Resource Person programs. Between Friday and Monday, each volunteer contacted their legislator and the amendment was defeated.

She explains that before resource people can contact their legislators, they must establish a good relationship. She says that after the initial contact with the legislator, Medical Resource people are urged to nurture their friendships by offering to help the legislator in some constructive ways. "For instance, the resource person can help keep the Legislator informed of the feelings of his constituents, offer to have a coffee for the legislator, or ask him to speak at a local function."

Although the organization must limit itself to legislative activities, individuals can become politically active. "In fact, we strongly encourage resource people to offer to help the legislator with his campaign at election time."

By establishing this good rapport, both resource people and legislators benefit. Resource people feel more

continued on page 67

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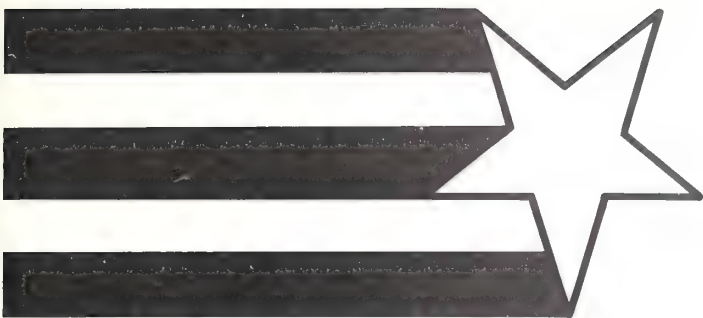
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The Federal Front

By Karen S. Edwards with D. Brent Mulgrew, J.D.

Of the hundreds of medical bills pending in Washington, there are three issues which are of major concern to organized medicine in Washington — whether the year is 1981, 1982, or 1983 — and those issues are Budget, FTC and Health Planning. These are the areas which have engaged the primary attention of OSMA's Federal Legislation Director — and the attention of practically everyone in Washington — for the past two years. A synopsis of their past, their present, and their future follows:

Budget

The past: Suddenly, Washington was changing its tune. The election of 1981 brought in an unprecedented Republican takeover of the U.S. Senate (the first time the GOP has controlled either House in 25 years), and a President who aimed to change the way the U.S. government did its business. Ronald Reagan managed to force Congress to accept his economic program — on a series of budget votes.

His program hinged on two acts: the Omnibus Budget Reconciliation Act of 1981 (with \$37 billion in program cuts)

and the following year a tax bill. Health care did not fare well under either. The Omnibus Budget Reconciliation Act alone contained over 40 provisions relating to the Medicare/Medicaid programs, and the new Administration had already developed a "black book" detailing a series of program cuts in health care. Major components of this "black book" included the ill-fated "Medicaid cap," selected Medicare cuts, block grants for categorical health programs; gradual elimination of health planning and PSRO. By adroitly using the new reconciliation process, the President was able to force a single vote in each House on the proposed cuts, while successfully preventing individual constituencies and Congressional Committees from getting budget increases for selected programs.

The present: During 1982, budget was again at the forefront as health care costs were further reduced. OSMA directed much of its efforts toward attempting to dilute or defeat the Tax Equity and Financial Responsibility Act (TEFRA), which contained a number of significant changes in the tax law — including statements reducing maximum contributions to a pension plan from

\$45,475 to \$30,000 and lowering maximum annual benefits from \$136,425 to \$90,000. The Act also made spending cuts in Medicare and Medicaid totaling \$12.8 billion and \$1.4 billion, respectively, over the next three fiscal years. Despite OSMA's effort, the Act was signed into law.

The future: The Medicare and Medicaid programs will no doubt continue to come under Federal scrutiny this year, and possibly the New Federalism legislation, which was stalled in last year's Congress, will move this year. This program sought to transfer welfare and food stamp programs to the states, in exchange for the federal government assuming the funding for Medicaid. The program also included a "turnback" provision, returning 43 federal programs to state governments.

Health Planning

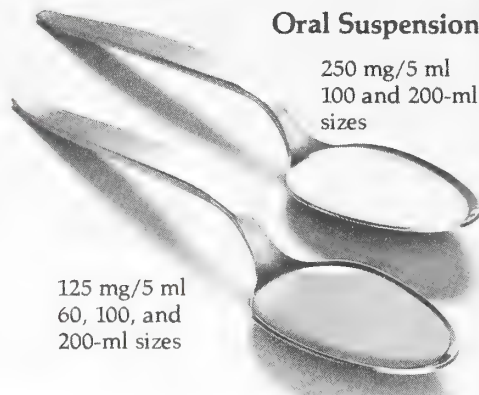
The past: The federal health planning law came under major modification in 1981. The annual authorization for the program was reduced to \$102 million under the Budget Reconciliation Act, but more significantly was the law which permitted the Governor of each state to terminate or take over those Health

continued on page 51

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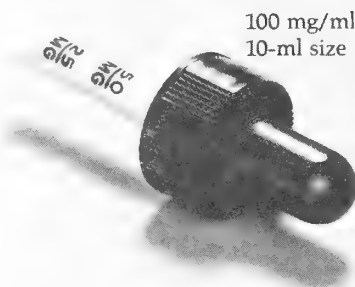


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The Federal Front

Systems Agencies located within the state. (In Ohio, they have been consolidated under the Ohio Department of Health.) The Act also permitted the Secretary to waive current requirements for appropriateness review.

The present: The OSMA has been working with the AMA for repeal of health planning. The AMA has indicated its support in this area for voluntary, locally based health planning and shared with the subcommittee on Health and Environment (of the House Energy and Commerce Committee) its own principles on voluntary health planning.

The future: The OSMA will continue

to work with the AMA toward requesting repeal of the Health Planning Act during 1983 but success will be difficult considering the makeup of the new Congress.

The FTC

The past: It was not mere chance that made Congressman Thomas A. Luken (D-Cincinnati) introduce a bill before the 1981 House of Representatives, limiting the powers of the Federal Trade Commission (FTC) over state-regulated professions.

The OSMA, under a directive of the 1981 OSMA House of Delegates, worked with Congressman Luken in developing the bill, and supported

him when he took it to Washington.

The bill as written would severely limit the powers of the FTC by placing a moratorium on its actions against state-regulated professions — including medicine. (For further background on this bill, see the article, "Congressman Luken and the FTC," (Ohio State Medical Journal, August, 1981.)

The present: There has been a flurry of legislative activity surrounding this bill, ever since Congressman Luken introduced it. Much interest, of course, has stemmed from the fact that the FTC's authorization ran out late last year, so groups have been attempting to clarify the jurisdiction of the FTC through federal legislation. (The AMA's effort to clarify the FTC's jurisdiction, earlier, through the Supreme Court, ended in a disappointing tie vote — so it was back to the U.S. Congress.)

Unfortunately for the AMA, the FTC had not been sitting idly by while the medical group was waging its court battle. Instead, it supported a bill introduced into the House (HR6995), which would extend the FTC's operating authority for three years, continue the two-house Congressional veto of FTC rules, provide a definition of unfair acts and practices, and make other changes in FTC authority.

A battle between group supporting HR 6995 and the Luken-Lee Bill (S-2499) ending FTC jurisdiction of state-regulated profession has been inevitable, but the outcome looked promising as the Senate finally approved S-2499 late last year . . . a victory for both the AMA and the OSMA. But through a series of legislative maneuvers, the bill was stalled until the lame duck session.

The future: The AMA has made FTC legislation its number one priority, and so it will continue to be a major concern of the OSMA's Federal Legislative department this year. **OSMA**

The FTC . . . and a Victory

After a year and a half of discussion, the United States House of Representatives approved HR 6995, the FTC authorization bill, and included OSMA-supported language limiting the authority of the FTC. The House completed consideration of an \$85 billion authorization bill for HHS (Health & Human Services) early on December 1st. The FTC authorization bill had been on the calendar since the start of the lame duck session and was made the next order of business without notice to either proponents or opponents.

At the moment the bill was scheduled, Congressman Luken was being elected by the Ohio Democratic Delegation to the Steering and Policy Committee of the U.S. House. His election to this influential policy-making committee alone would have made his day, but suddenly he was faced with a major floor fight on the FTC bill he had been guiding for the last 18 months. Congressman Luken returned to the House floor and for the next few hours stood almost alone coordinating the floor debate in support of the OSMA-AMA supported language. His prime Republican cosponsor, Congressman Gary Lee, never appeared on the floor throughout the debate. An amendment was proposed by

Congressman Broyhill that would have "gutted" the Luken-Lee amendment by stating that the FTC would have jurisdiction over the "business activities" of the professions.

When the Broyhill substitute was considered, Luken rallied his troops and beat the Broyhill amendment 208-195. At this writing, the Senate has refused to consider either bill, and a continuing resolution without the critical Luken-Lee language is being drafted. After the Broyhill amendment was defeated, the House considered the Luken-Lee amendment. It was adopted 245-155.

Addition of the Luken-Lee language to HR 6995 is a major step in the process, but the battle is not over. The Senate must consider either HR 6995 or S 2499, the Senate bill with a similar provision pending in the Senate since April. The vote against Broyhill was necessary to illustrate the will of the House supporting a moratorium on the FTC's authority to investigate professionals and their associations. The Ohio Congressmen who joined Luken in opposing Broyhill were: Hall (D-Dayton), Latta (R-Bowling Green), McEwen (R-Hillsboro), Kindness (R-Hamilton), Weber (R-Toledo), Wylie (R-Columbus) and Ashbrook (R-Johnstown). — D. Brent Mulgrew, J.D.

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal. D. Brent Mulgrew, J.D., is Associate Director, OSMA, Director, Department of State and Federal Legislation.



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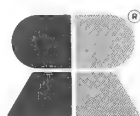
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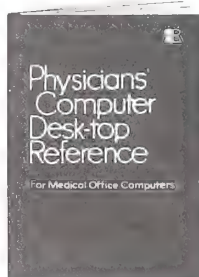
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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephadrine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae*, staphylococci, and

S. pneumoniae; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli*, *P. mirabilis*, *Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use). In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephadrine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis.

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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The following adverse reactions have been reported following use of cephadrine: G.I. — Symptoms of pseudo-membranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Blood — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structures infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h.).

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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Dr. Ford goes to Washington

By Carol Wright Mullinax

C. Douglass Ford, M.D., Toledo, pauses a moment before he begins his day in Washington.

(Photos by D. Brent Mulgrew, J.D.)

It had all the makings of a classic movie. A small-town Jimmy Stewartish-type doctor treks to Washington to straighten out the lawmakers. But much more than learning a few lines was at stake when C. Douglass Ford, M.D., Toledo, President of the OSMA, travelled to the Capital City this fall. At the request of the American Medical Association, 38 state medical society presidents gathered in Washington on September 13, 14, and 15 to do some personal lobbying on the Federal Trade Commission bill.

It was one more battle in the war the FTC has been waging against the AMA for the past seven years. To a greater extent than most government bureaucracies, the FTC has been seeking to expand its power by assuming jurisdiction over the profession. In 1975 it filed a complaint

against the AMA, charging that the principles of medical ethics, insofar as they prohibited physicians' advertising and solicitation and interfered with physicians' contractual relationships with HMOs, were anticompetitive in violation of the Federal Trade Commission Act. This suit was filed in spite of the fact that the AMA had long abandoned any restrictions on these matters.

In September, Congress had before it a bill which renewed the authority of the FTC. Included in that bill was an amendment (HR 3722 authored by Ohio Congressman Tom Luken) which would rein in the FTC's desire to regulate the professions — including doctors, lawyers and dentists. In an effort to get the bill through Congress, the AMA requested state presidents to help with the lobbying.

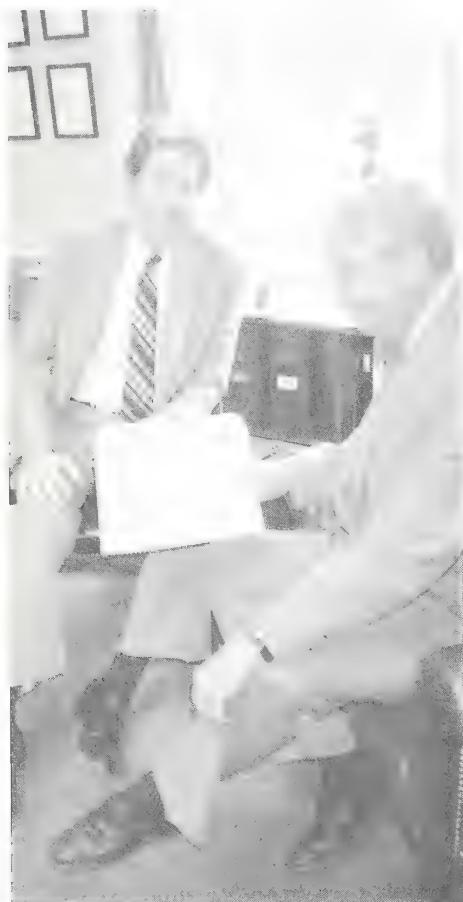
On Monday, September 13, sleepy-

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eyed from a morning which began at 4 AM with rounds at the Toledo Hospital, Dr. Ford attended a briefing at AMA Headquarters in Washington. Flanked by OSMA Executive Director, Hart Page, and Associate Executive Director and Director of State and Federal Legislation, D. Brent Mulgrew, Esq., Dr. Ford listened as AMA officials and staff briefed the medical society presidents on the background of the bill and AMA policy.

Facts in hand, the state presidents converged on the Capitol for a full day of appointments

Of special concern to the AMA was the misconception that the medical profession was asking for exemption from federal antitrust laws. It asked the presidents to point out to skeptical lawmakers that the U.S. Department



A briefing was held by the AMA before the lobbyists went on their rounds.

of Justice, state attorneys general, and private individuals can all challenge the anticompetitive practices of professionals. Further, states have regulatory licensing and consumer fraud authority and can bring action against deceptive acts and practices and unfair trade practices. The AMA also asked the Presidents to point out that Congress, in its wisdom, never authorized the FTC to regulate professional associations and that the FTC, by assuming that responsibility, was preempting state laws governing professionals.

Finally, the Presidents were asked to explain their opposition to a proposal by Congressman Jim Broyhill (R-NC), which would grant the FTC authority over the profession in their "business activities."

Facts in hand, the state presidents converged on the Capitol. Most physicians made the rounds on Monday and Tuesday, but since many Ohio Congressmen had returned home to campaign, Dr. Ford went back to Toledo and returned to Washington on Wednesday, September 15.

OSMA Legislative Staff had arranged a full day of appointments for him with those congressmen with whom they felt Dr. Ford's personal

lobbying would be most effective. The first meeting, with Congressman Ron Mottl (D-Cleveland), was encouraging. As a member of the Commerce and Energy Committee, Representative Mottl had heard the Luken-Lee Legislation and was familiar with organized medicine's view. He promised to work closely with medicine and, if his vote was needed, he pledged his support. (Surprisingly, when the vote occurred in December, Mottl voted for Broyhill and against Luken-Lee.)

Dr. Ford's next stop was equally encouraging. Chalmers Wylie (R-Columbus) appreciated Dr. Ford's personal contact and enjoyed a visit with his long-time neighbor, Hart Page. He too promised support and gave Dr. Ford the names of several other Republicans whom he felt should be contacted.

It was a long way to travel to meet someone from your hometown, but Dr. Ford's visit with his representative, Ed Weber (R-Toledo) proved to be well worth the effort. Congressmen are always more responsive to constituents than special interest groups, and Representative Weber was no exception. He was very interested in the FTC issue and already had met with the Medical Society of Toledo and

continued on page 60

Left: Dr. Ford meets with Chalmers Wylie (R-Columbus)

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Please see adjacent page for brief summary of prescribing information

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Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: Drug Dependence: Codeine can produce drug dependence of the morphine type, and may be abused. Dependence and tolerance may develop upon repeated administration. Prescribe and administer with the same degree of caution appropriate to the use of other oral narcotic medications. Subject to the Federal Controlled Substances Act (Schedule III).

Precautions: Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture

Information for Patients: Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking this drug should be cautioned accordingly

Drug-Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety, or other CNS depressants (including alcohol) concomitantly with acetaminophen and codeine may exhibit additive CNS depression due to the codeine component. When such therapy is contemplated, the dose of one or both agents should be reduced

The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine

The concurrent use of anticholinergics with codeine may produce paralytic ileus

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, acetaminophen and codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards

Nursing Mothers: It is not known whether the components of this drug are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when acetaminophen and codeine are administered to a nursing woman.

Adverse Reactions: Most frequently: Lightheadedness, dizziness, sedation, shortness of breath, nausea and vomiting. More prominent in ambulatory than in non-ambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Others: Euphoria, dysphoria, constipation and pruritus.

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Dr. Ford goes to Washington

(continued)

Lucas County. He pledged his cooperation on the bill, and voted with us in December.

Meetings with the staff of Congressmen Michael Oxley (R-Findlay) and Clarence J. Brown (R-Urbana) also resulted in pledges of cooperation. But on the day of the vote, they voted for the Broyhill amendment, before supporting the Luken moratorium. Ralph Regula (R-Canton) in a brief meeting with Dr. Ford, expressed his concern at the AMA's attempt to "exempt itself from antitrust." Despite a reputation of loquacity, Dr. Ford was unable to change his mind on that day, but in December, he supported Luken-Lee, after voting for the Broyhill amendment.

Dr. Ford's day ended back at the AMA headquarters in Washington for a debriefing where the results of the day were presented to the AMA staff. Finally, the bone-tired President was able to board the plane and return home. It was a long and exhausting day but the AMA and OSMALegislative Staffs felt that on such an important bill (the AMA has made the FTC bill its number one legislative priority) the credibility and prestige of its leadership could go a long way in influencing the Congress. **OSMA**

Carol Wright Mullinax is the Associate Director, Department of Communications

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REFRESHER SEMINAR IN PEDIATRICS FOR PEDIATRICIANS AND FAMILY PHYSICIANS: March 23-24; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$120, \$60 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

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patients are taken off of all addicting drugs for pain.

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Harmarville Rehabilitation Center, P.O. Box 11460, Guys Run Road, Pittsburgh, PA 15238

The 1983

OSMA ART and CULTURE COMMITTEE'S

Photographic Exhibit



"Comrades" by Marvin Aronoff, M.D., Cincinnati

The Ohio State Medical Association's Art and Culture Committee will sponsor a photographic exhibit and competition. The 1983 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1983 Annual Meeting, Columbus, where the entries will be displayed. Winners will not necessarily appear on future Journal covers.

Photographs may be entered in two divisions: Black and White, and Color.

Entries must be in print form (8" x 10" or 11" x 14") in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a \$10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

Name _____

If Nonmember, Spouse's Name _____

Street _____

City _____ State _____

County _____ Zip _____

Telephone _____

Information about photograph:
(provide as much as possible)

Camera _____	Lens _____
Speed _____	Aperture _____
Subject _____	Film Type _____
Date _____	Time of Day _____
Title _____	

Division: ☐ B & W ☐ Color

Processing/Printing: ☐ Professional ☐ Self

Mail or hand carry the photograph, entry form and \$10 entry fee (make checks payable to The Ohio State Medical Association) to: The Ohio State Medical Association Photographic Exhibit, 600 S. High Street, Columbus, Ohio 43215. All entries must be received no later than April 12, 1982.

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Obituaries

C. JOSEPH DE LOR, M.D., Columbus; Ohio State University College of Medicine, 1934; age 75; died November 9, 1982; member OSMA and AMA.

ARTHUR GINZLER, M.D., Warren; Wayne State School of Medicine, Detroit, 1932; age 74; died November 2, 1982; member OSMA and AMA.

C. LEE KEIDEL, M.D., Cleves; Indiana University School of Medicine, Indianapolis, 1925; age 80; died October 20, 1982; member OSMA and AMA.

JOSEPH KOEHLER, M.D., Dayton; University of Cincinnati College of Medicine, 1928; age 79; died October 27, 1982; member OSMA and AMA.

EDWARD MARSHALL, M.D., Cleveland; Hahnemann Medical College and Hospital, Philadelphia, 1930; age 79; died October 30, 1982; member OSMA.

AKIN MUEGEL, M.D., Cincinnati; University of Cincinnati College of Medicine, 1938; age 68; died October 21, 1982; member OSMA and AMA.

JOSEPH O. PORTER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1964; age 48; died October 25, 1982; member OSMA and AMA.

RUSSELL RIZZO, M.D., Cleveland; Case Western Reserve University School of Medicine, 1944; age 61; died October 14, 1982; member OSMA and AMA.

JACOB WERLE, M.D., Cleveland; Case Western Reserve University School of Medicine, 1937; age 70; died October 21, 1982; member OSMA and AMA.

WILLIAM CORZINE, M.D.,

Chillicothe; University of Maryland School of Medicine, 1947; age 60; died October 27, 1982; member OSMA and AMA.

DAVID DANENBERG, M.D., St. Clairsville; University of Michigan Medical School, Ann Arbor, 1925; age 82; died October 19, 1982; member OSMA and AMA.

1982 Health Care Legislation: A very good year

(continued)

"umbrella" license instead of individual licenses for each of the various units within the EMS system.

What it says: The new law permits emergency medical service systems to

obtain one license for all units, instead of individual licenses for each of the units within the EMS systems. The amendment contained in the law specifically exempts physicians, whether in individual, group or corporate practice from licensure as terminal distributors of dangerous drugs.

What it means to you: With the new law, all physicians will be exempted from Pharmacy Board licensure beginning in 1983. The Pharmacy Board sent license applications to physician corporations, but they should be ignored. Physicians who mistakenly submitted payment for the '83 licenses should request the return of the \$50 fee.

INDEMNIFICATION AND REPRESENTATION FOR PHYSICIANS TREATING WARDS OF THE STATE (SENATE BILL 204)

Background: This bill originated from concern by physicians over frivolous malpractice suits brought by

prisoners against private practitioners, and from concern by the Department of Rehabilitation and Correction over a potential shortage of medical personnel to treat prisoners. The bill was designed to cover those physicians who become the object of suits brought by wards of the state, particularly prisoners of the state penal institutions.

What it says: Under this new law, any physician who renders medical services to a ward of the state, pursuant to a personal services contract with a state agency, will be considered an "officer or employee" of the state, and entitled to representation, immunity or indemnification in any civil actions arising from such services.

What it means to you: The new law provides malpractice protection to physicians who work under contract with the State of Ohio.

LIMITED IMMUNITY FOR VOLUNTEER SPORTS PHYSICIANS (SENATE BILL 159)

continued on page 67

The one and only

If you've always thought there was something special about OSMA's Federal Legislative program, you're right. The OSMA is the only State Medical Association to maintain regular on-site communications with the AMA's Washington office, and Ohio's Congressional representatives who decide many of the health care issues facing medicine today.

Every six to eight weeks, D. Brent Mulgrew, J.D., the Director of OSMA's Department of Legislation, goes to Washington to meet with AMA lobbyists and Ohio's representatives — to keep them in touch with the views and thoughts of Ohio physicians.

The bonus is that the ongoing relations built up by Mulgrew at the Federal level, have gone a long way toward maintaining good access to the U.S. Congress. — Karen S. Edwards

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At Ohio Center
350 N. High Street
Columbus, Ohio 43215

1982 Health Care Legislation: A very good year

(continued)

Background: The OSMA supported this legislation on the recommendation of the Sports Medicine Committee of the OSMA. The language of the bill was an explicit extension of the protection of Ohio's Good Samaritan Act.

What it says: This new law provides qualified immunity to athletic physicians or nurses who provide emergency medical care or first-aid treatment to participants in school athletic events. However, the law does not extend the immunity to any physician or nurse who receives remuneration for their services.

What it means to you: Physicians who are (or are considering) serving as voluntary team physicians for their communities are protected from liability and civil damages, unless their actions constitute willful and wanton misconduct.

Finally, in the area of federal legislation, the Department has worked with Ohio Congressmen and staff, as well as the AMA and national medical specialty societies on such issues as FTC (see related story, "Dr. Ford Goes to Washington," elsewhere in this issue), pension regulation and tax and fiscal measures.

The Personal Touch

(continued)

comfortable approaching their legislator on vital issues, and legislators, recognizing their limited knowledge in certain areas, welcome the insight provided by a trusted, accurate source.

This element of trust is essential if resource people are to obtain the two things they want most from their legislator: 1) to be able to get through to him in a moment's notice; and 2) an honest answer, even if the legislator is not always in 100% agreement.

Through these open lines of communication, the Auxiliary project has been credited with playing a major role in the outcome of numerous important legislative issues. The most recent issues include:

- The Federal FTC Bill (HR 6995)
- Involvement with the medical licensure (HB 317)
- Hospital (HB 173)

Victories such as these make the MRP program a valuable asset and worthwhile program. "The need for this program will be even greater as health care is increasingly being referred to as an industry, and the forces of competition are entering into medical planning consideration. As physicians make a concerted effort to project an image of the caring, skilled provider of quality care, the Auxiliary must think of itself as the public relations arms and the marketing force behind the product which the physician has to offer."

Vesper notes under the strong leadership of Vallerie Vollmer, and the hard-working, dedicated volunteers, the program will continue to grow and flourish. "Our aim, to develop more and more 'friendships with a purpose' will prove increasingly valuable, if we remember that our program's goal is to motivate, not manipulate, our legislators to consider medicine's point of view." OSMA

Gina DiBlasio Cummins is Editor of Synergy, and a staff writer for the Journal

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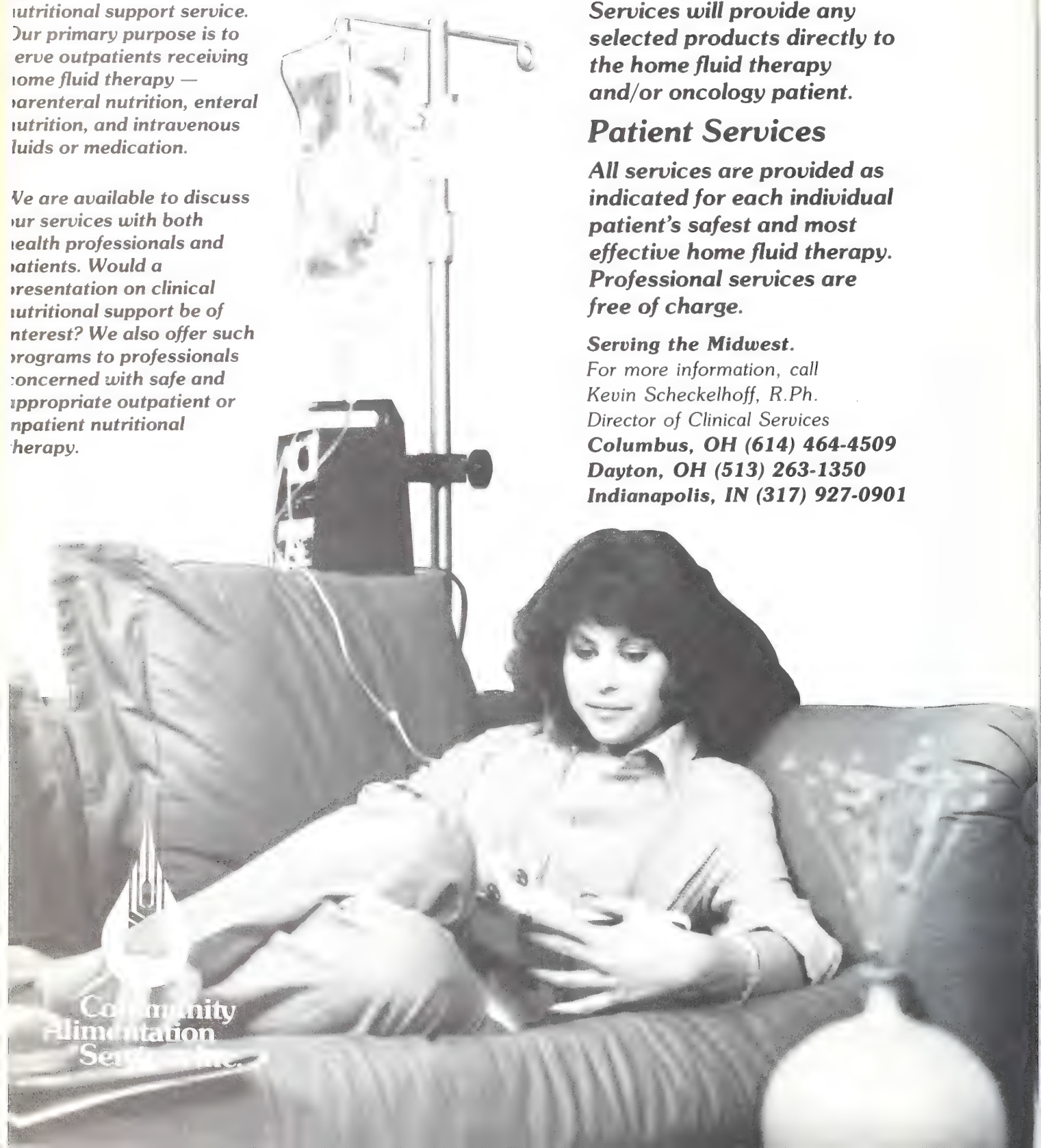
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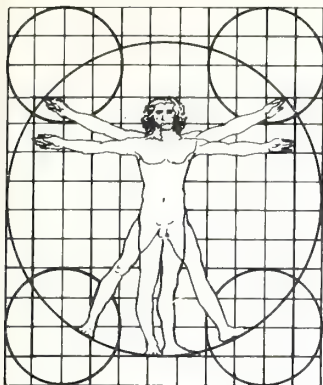
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CLINICAL & SCIENTIFIC

CONTINUING MEDICAL EDUCATION IN A CONSORTIUM APPROACH: THE MAHONING SHENANGO AREA HEALTH EDUCATION NETWORK EXPERIENCE.

W. Robert Kennedy, Ph.D.

Richard Juvancic, M.D.

Edward Kessler, M.D.

William Bunn, M.D.

Margaret Drummond

Continuing medical education programming and administration have been uniquely developed in a three-county area of Ohio and a two-county area of Pennsylvania through the Mahoning Shenango Area Health Education Network (MSAHEN). Member institutions, with financial support from all attending staffs, jointly cooperate in the MSAHEN Medical Education Committee. This body, its structure, functions, and activities are described. Accredited programs have uniform quality and the region has more adequately defined educational offerings through the use of this consortium approach.

HISTORICAL ASPECTS

The Northeastern Ohio Regional Medical Program (NEORMP) successfully highlighted the need for a coordinating body for continuing medical education to efficiently bring together the diverse elements in the Greater Youngstown area. The NEORMP established a task force which sought federal funds from RMP in 1971. The membership of this body comprised five contiguous counties: Mahoning, Trumbull, and Columbiana in Ohio; Mercer and Lawrence in Pennsylvania, which together developed a five-pronged approach to continuing education, more ambitious than elsewhere in the country at the time. The major areas addressed were medical, dental, nursing, allied-health, and community-health education.

Federal funding was secured, and MSAHEN was incorporated under Ohio law and an executive committee established. Shortly thereafter, a small staff was employed and the previous five working committees were appointed. Programs were initiated and success came rapidly. Unfortunately, the NEORMP was discontinued, but the MSAHEN leadership felt it essential that the organization be maintained.

To offset costs, various projects were undertaken. In the area of continuing medical education, physicians in the respective participating hospitals within this five-county area were willingly assessed at a rate of \$15 per staff member (deductible from the annual staff dues), thereby enabling MSAHEN to continue its activities as a consortium.

The MSAHEN model has been successful for nearly a decade. The recently funded Ohio Area Health Education Network (AHEC) was patterned after the MSAHEN in terms of its organizational structure and management model. The success of MSAHEN has come about through physician support, the minimization of costs to area hospitals for their programs, the centralization of record keeping and documentation, and the willingness to assist in program planning and evaluation of all types.

This article focuses upon the model which has been developed.

Dr. Kennedy, Youngstown, Chairman, MSAHEN Medical Education Committee, 1980-1982; Associate Dean for Clinical Affairs, St. Elizabeth Hospital Medical Center, Youngstown; and Associate Professor of Medical Education, Northeastern Ohio Universities College of Medicine, Rootstown.

Dr. Juvancic, Youngstown, Vice Chairman, MSAHEN Medical Education Committee, 1980-1981; Coordinator of Medical Education, Youngstown Hospital Association; and Associate Professor Family Practice, Northeastern Ohio Universities College of Medicine, Rootstown.

Dr. Kessler, Youngstown, Cochairman, MSAHEN Medical Education Committee, 1975-1980; Active Staff, Director of Dialysis Services, and Chief of Nephrology, St. Elizabeth Hospital Medical Center, Youngstown; Professor of Medicine, Northeastern Ohio Universities College of Medicine, Rootstown.

Dr. Bunn, Youngstown, Cochairman, MSAHEN Medical Education Committee, 1975-1980; Chairman, Department of Medicine, Youngstown Hospital Association; and Chairman, Council of Internal Medicine, Northeastern Ohio Universities College of Medicine, Rootstown.

Ms. Drummond, Youngstown, Executive Director MSAHEN.

Reprint requests to St. Elizabeth Hospital Medical Center, P. O. Box 1790, Youngstown, Ohio 44501 (Dr. Kennedy).

Submitted July 2, 1981.

MEMBER INSTITUTIONS

The MSAHEN is a unique organization spanning an area of Ohio and Pennsylvania with a combined population approaching one million individuals. Within this area, six major health care institutions participate in a joint continuing medical education endeavor. These include Youngstown Hospital Association, St. Elizabeth Hospital Medical Center, Trumbull Memorial Hospital, Sharon General Hospital, St. Joseph Riverside Hospital, and East Liverpool Hospital. Physicians in these institutions total 542.

The passage of required continuing medical education legislation by Ohio in 1976 and soon followed by similar legislation in Pennsylvania, led to the review of MSAHEN as a possible agency for accrediting programs in the member hospitals. This was accomplished in September 1976, and approval given for a two-year period.

The philosophy underlying this cooperative endeavor is described as follows:

1. MSAHEN accreditation was in the best educational interests of the medical community, member hospitals, to the developing Northeastern Ohio Universities College of Medicine, and the endeavoring AHEC program in Ohio.

2. MSAHEN accreditation and appropriate programmatic implementation was cost effective and efficient for the physicians and institutions within this region.

These two considerations provided the foundation upon which the continuing medical education was developed. Following the guidelines of the Ohio State Medical Association and the Pennsylvania Medical Association, requirements were instituted concerning programs and activities which could qualify for Category I sponsorship and cosponsorship. The use of MSAHEN staff naturally occurred since the centralized capability allowed for appropriate documentation and record keeping. In addition, the staff was responsible for providing a wide variety of services including guidelines for developing programs, consultation as needed, arrangements for meetings and activities not held within member institutions, and communication with area physicians.

MSAHEN ORGANIZATIONAL STRUCTURE

The Continuing Medical Education Committee of MSAHEN is formally charged with providing cosponsorship opportunities to area institutions, organizations, and societies. The Committee also engages in planning and coordinating efforts to identify areas of continuing medical education needs found by physicians in the region as well as in their own hospitals. A vital service by the Committee is to develop cosponsorship opportunities for those interested in providing periodic programs of potential interest to physicians. To increase communication, MSAHEN developed an area-wide calendar which is produced regularly and distributed to all institutions and physicians. This also lists nursing, allied health, and other activities of possible interest.

Each member institution of MSAHEN has two delegates to the MSAHEN Continuing Medical Education Committee. The individuals generally are representatives from each institutional continuing medical education committee. This strategy is an attempt to assure a continuity of program quality. Each representative is responsible for completing all paperwork and being an "advocate" for proposed activities with cosponsorship status. Each member institution is required to have the following:

1. A functioning hospital committee on continuing medical education.

2. An overall plan to ensure appropriate educational program development for the medical staff.

3. A mechanism for reviewing and forwarding to the MSAHEN Medical Education Committee all applications for cosponsorship.

4. The annual membership fee to cover the costs of services and cosponsorship activities with MSAHEN.

Recently, member institutions voted to have a review conducted of their entire program once every 24 months. In addition, member institutions voted approval to use MSAHEN services for program support such as brochure development, publicity, registration, etc. This assures that services available by central staff would be appropriately utilized. In addition, member institutions must develop and forward to the MSAHEN Continuing Medical Education Committee an annual report delineating their areas of activity, needs to be addressed, and their success as perceived by their staff.

OVERVIEW OF MSAHEN

MSAHEN has functioned as an accredited body for approximately six years. During this time, hospital medical staffs and area physicians have been provided programs recognized for quality which have served a variety of institutional educational needs. Because of the MSAHEN model of review and cosponsorship, greater preplanning or programs has occurred by the hospital medical staffs resulting, we believe, in improved cooperation and program quality. With the addition of new hospitals to the MSAHEN consortium efforts are made to assure that they have available adequate consultation to establish their committee, undertake educational planning, and institute programs needed locally. To this end, committee members provide assistance as needed.

Recently, a faculty resource program has been developed and nearly 100 physicians from member institutions have indicated their willingness to teach upon request. MSAHEN central staff provides coordination while fees are handled on a hospital-to-faculty member basis. This service has greatly reduced the demand upon specific individuals within member institutions while simultaneously expanding the role and mission of MSAHEN to provide an additional service otherwise difficult to secure. In several instances, such activities have been extended beyond member institutions and involved professional medical societies, area organizations, and other health care institutions.

YEAR	PROGRAMS	HOURS
76-77	9	147½
77-78	64	459½
78-79	57	324
79-80	107	1397½
TOTAL	237 programs	2328½ hours

in this region. Since education has been traditionally viewed as a shared endeavor, there has been no problem in viewing undergraduate medical education in this context. Therefore, the establishment of faculty committees and the delineation of activities have occurred on the basis of interests and faculty enthusiasm with minimal concern for institutional loyalties.

In addition, the Area Health Education Network which has used MSAHEN as a central site within Region III, has been utilized to effectively develop planning programs and increase the flow of support for projects within the area. This enhanced utilization of resources would have been undertaken slowly had it not been for the existence of MSAHEN. The MSAHEN experience is difficult to assess and document in terms of dollars saved. However, it clearly has removed the necessity for each institution is establishing a bureaucracy for development and maintenance of Category I responsibilities. Since this function is maintained by MSAHEN central staff and program approval is provided by the Committee, the necessity for each institution developing its own resources has been minimized. Further, since programs are reviewed by the Committee wherein peers from other institutions have the opportunity to critique and improve applications, the quality of the planned events has been enhanced, a fact which otherwise might not have occurred.

Within hospitals, it often is difficult to have continuing medical education activities introduced in a uniform and logical way without one department trying to have more programs accredited than quality would allow. Since all applications now are given joint review and considerations, such multiplicity of activities has been minimized. Furthermore, through the cosponsorship mechanism, the MSAHEN Continuing Medical Education Committee has greatly strengthened educational opportunities available to area societies and agencies. These groups, generally with limited resources, have been provided

logistical support for programming without burdening their membership or using other types of support thereby incurring additional costs. Through this mechanism, MSAHEN annually reviews numerous programs that would otherwise have gone elsewhere for accreditation and possibly not have been given review at all.

During its continuing medical education activities, Category I credit approvals have grown as follows:

SUMMARY

It is the consensus of the MSAHEN Board of Trustees and the Continuing Medical Education Committee that the viability of the MSAHEN model has significantly improved continuing medical education within our region. Further, it has enabled the development of cooperation on a regional basis which is more positive in relation to our respective educational missions such as undergraduate medical education, nursing education, allied health, and community education. The organization has done much to bring into focus community needs rather than single institutional need, and to decrease the number of reduplicated programs engendered principally by institutional competitive pride. The mechanism of the MSAHEN provides for discussion, dialogue, and cooperation. This has offered a vehicle through which hospitals may discuss other pertinent issues. Attending staffs have found the MSAHEN approval to support quality education and readily have provided financial and other support to maintain this unusual consortium approach.

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GROUP PRACTICE IN NORTHERN OHIO has opening for general surgeon - board eligible - willing to do small amount of general practice. Small community near large metropolitan areas. Reply to Box No. 915, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

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WANTED OTOLARYNGOLOGIST to join a multispecialty clinic with facilities for doing all types of surgery. Rugeley and Blas-ingame Clinic Association, P.A., 2100 N. Fulton St., Wharton, Texas 77488. Telephone: (713) 532-1700.

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The OSMA and the AMA will cosponsor "Gearing Up for Retirement," March 18, 1983 at the Marriott Inn North, Columbus, Ohio. The program will inform physicians and their spouses of the considerations in planning for retirement and closing a medical practice due to retirement or death.

Alternative to dialysis should be used with care

Many patients with kidney failure can be freed of using home or hospital dialysis machines through an alternative that treats their condition while allowing them the mobility to lead normal, economically productive lives.

Continuous ambulatory peritoneal dialysis (CAPD) can enable selected patients with end-stage kidney disease to manage their own treatment independently by using a dialysis system worn under clothing, according to a report by the American Medical Association Council on Scientific Affairs in a recent issue of the *Journal of the American Medical Association*.

The CAPD user instills two liters of dialysate liquid into his peritoneum (abdominal cavity) through a catheter that is permanently implanted in his abdominal wall. After instillation, the plastic bag that contained the dialysate is rolled up — still attached to the catheter — and carried in a cloth waist purse under the clothing. The dialysate remains in the abdominal cavity for four to six hours, during which normal body wastes diffuse into it from capillary blood vessels in the membrane lining the abdominal cavity. After the diffusion period, the dialysate is drained back into the bag, which then is discarded; a new bag of dialysate is attached to the catheter and fresh liquid is instilled. The patient exchanges dialysate four or five times a day, seven days a week.

The process offers its users — 4,000 in the United States and 6,000 in other countries — distinct advantages over intermittent machine dialysis. By helping to maintain stable body weight, blood pressure and blood chemistry, CAPD helps patients avoid the sick feeling that can accompany machine dialysis. Diabetic patients can add insulin to the dialysate, eliminating the need for daily injections.

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Each prolonged action tablet contains: Phenylephrine Hydrochloride 25 mg
• Phenylpropanolamine Hydrochloride 50 mg • Chlorpheniramine Maleate 8 mg
• Hyoscyamine Sulfate 0.19 mg • Atropine Sulfate 0.04 • Scopolamine
Hydrobromide 0.01 mg • Each Ru-Tuss tablet acts continuously for 10 to 12 hours.

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Full range symptom-reliever for patients with air way congestion in the upper chest as well as the nose and throat.

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- Reduces sneezing • Eases breathing
- Tasty, so it's easy to take



To Relieve the Symptoms of Winter Weather Upper Respiratory Distress

RU-TUSS[®] / RU-TUSS[®] TABLETS EXPECTORANT

RU-TUSS[®]

Tablets

DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdoses may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets

Bottles of 500 Tablets

Federal law prohibits dispensing without prescription.

NDC 0524-0058-01

NDC 0524-0058-05

DISTRIBUTED BY:

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RU-TUSS[®]

Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyriminamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an anti-hypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease. Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: $\frac{1}{2}$ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: $\frac{1}{2}$ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

HOW SUPPLIED: (16 fl. oz.)

Pint Bottles

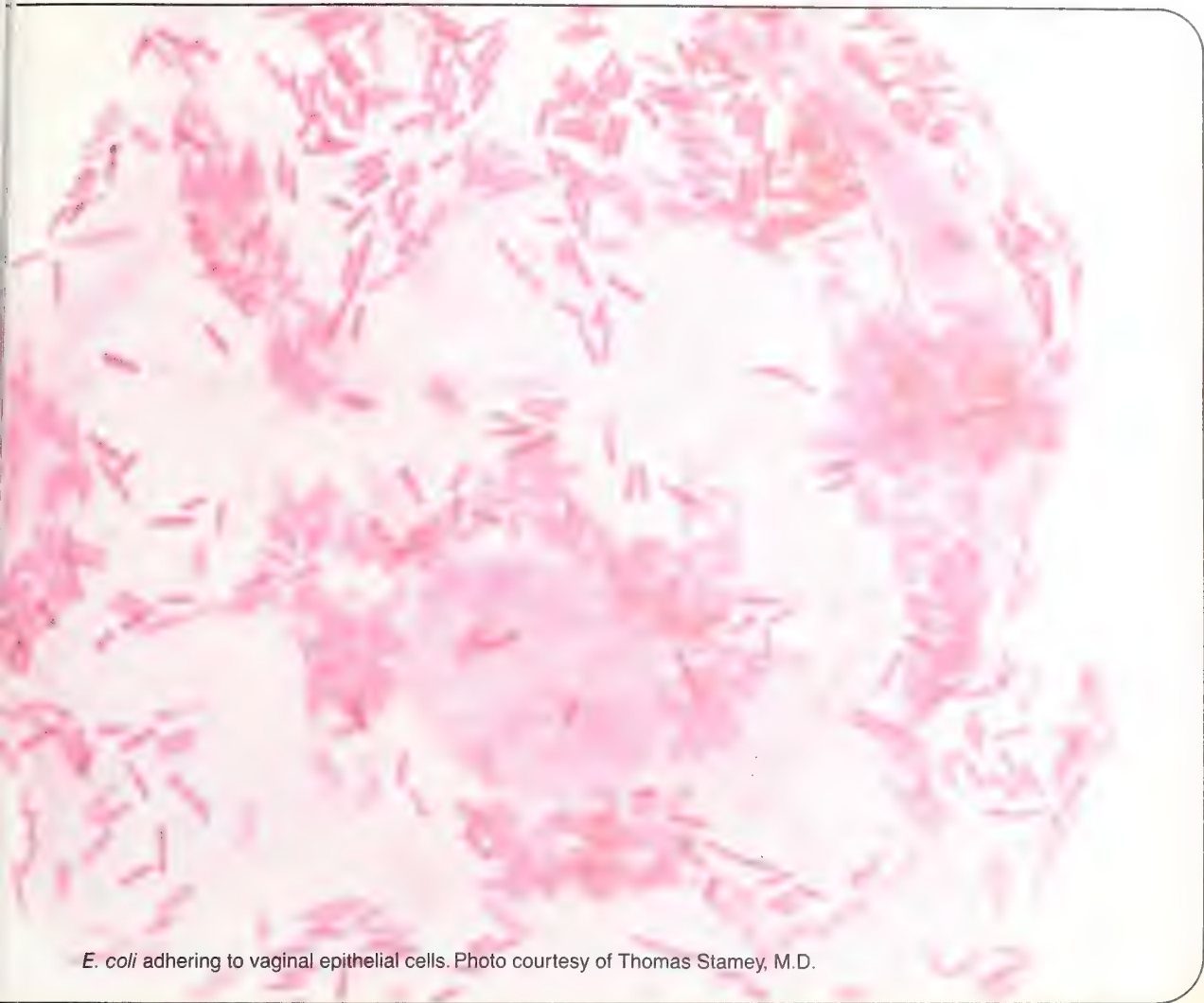
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NDC 0524-1010-16



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Pioneers in medicine for the family

cling to receptors



E. coli adhering to vaginal epithelial cells. Photo courtesy of Thomas Stamey, M.D.

The pharmacologic and pharmacokinetic activities of Bactrim (trimethoprim and sulfamethoxazole/Roche) make it particularly appropriate for the treatment of recurrent urinary infections.* The vast majority of *E. coli* strains and a wide spectrum of other common uropathogens are susceptible to Bactrim *in vitro*.⁴ Bactrim achieves high concentrations in the urine, and the trimethoprim component diffuses into the vaginal area and attacks susceptible uropathogens that cling to mucosal cells.⁵ In the fecal flora, Bactrim suppresses Enterobacteriaceae,⁶ with little resulting emergence of resistant organisms. Bactrim is contraindicated in pregnancy at term, nursing mothers, infants under two months of age and documented megaloblastic anemia due to folate deficiency.

Bactrim DS. Twice a day for 10 to 14 days in recurrent urinary tract infections.*

*Due to susceptible organisms such as *E. coli*, *Klebsiella-Enterobacter* and *Proteus* species.

BactrimTM DS
(trimethoprim and sulfamethoxazole/Roche)

Economical
and
effective
b.i.d.
therapy.

See next page for references and a summary of product information.

References: 1. Källén G *et al*: *Lancet* 2:604-606, Sep 19, 1981. 2. Lomberg H *et al*: *Lancet* 1:551-552, Mar 7, 1981. 3. Schaeffer AJ *et al*: *N Engl J Med* 304:1062-1066, Apr 30, 1981. 4. BacData Medical Information Systems: *Antibiotic Sensitivity Report*, Winter Series, 1981. 5. Stamey TA, Condly M: *J Infect Dis* 131:261-266, Mar 1975. 6. Rubin RH, Swartz MN: *N Engl J Med* 303:426-431, Aug 21, 1980.

Bactrim^{DS}

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL

PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hemopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose[®] packages of 100; Prescription Paks of 20 and 28 Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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A New Pushcart

By C. Douglas Ford, M.D.



C. Douglass Ford, M.D.

I remember a man who used to appear at my schoolyard with a pushcart containing a block of ice and a row of bottles filled with fruit-flavored water. He would put shavings from the ice into a paper cup and sprinkle one of the brightly colored flavors over those shavings. A cup of the flavored ice cost a nickel. I remember his product as being tasty and sought after, if one had a nickel to spend. Not many years later, he was displaced by a fellow who sold flavored water which had been frozen onto two sticks. His inventory was loaded on a truck which had a set of bells that played a recognizable but now forgotten tune. The bells, of course, alerted us all to the truck's approach. I think of the truck driver's capture of the pushcart owner's market as an example of successful competition based upon improved productivity and accessibility of a product. But the bells, my friend, are an example of effective marketing. The sounds of the bells on an ice cream truck still have an undeniable pull upon all of us who had that sort of childhood exposure.

This issue of the *Journal* is focused upon marketing and competition. Most of us who practice medicine in Ohio are comfortable with our present routines of making hospital rounds every day, and then going to the office to attend those of our patient-friends who turn to us for their health care as well as for help and support in the daily problems of living. Is that comfortable routine to become the

equivalent of the pushcart with the block of ice? If so, what then will become the equivalent of the ice cream truck? Equally important, perhaps, is the answer to the question of who is going to ring the bells and what tune will they play.

We all realize society spends a lot of money for health care. We recognize that the public assistance costs are expanding more rapidly than any liberal's wildest fantasy. I believe our nation is in an economic struggle of Titanic dimensions (to pick an ill-fated adjective). I am apprehensive that fee-for-service medicine will become a victim of that struggle.

"I worry about the public perception of physicians; a significant part of marketing, if you will . . ."

There are those who display data showing fee-for-service medicine as being inefficient or pointlessly costly. We, in turn, indicate that one cannot measure a physician's empathy or weigh a surgeon's skills. They claim that too many physicians (even some of us in Ohio) have too little empathy and our surgeons are "too busy" to

explain what they intend to accomplish with their skills. I worry, therefore, about the public perception of physicians; a significant part of marketing, if you will.

I have heard that Mr. Douglas Frazier, President of the United Auto Workers, cannot understand why his union members insist upon having the right to choose their own doctor as part of their health benefits. If you carry his perplexity to its logical end, you can conclude that Mr. Frazier (and he is not alone) envisions physician's services to be a commodity. A commodity whose price and volume can be regulated easily. The provision of those services could be treated as a product of a public utility. Each doctor could be assigned to an area of responsibility and each could be "plugged in" where needed geographically or technologically. Access would be rationed.

We have a system like that now. It is called the V.A. or the Army (or Navy, or Air Force) medical services. There is nothing wrong with military medicine, but it is different. The physicians in the military are quite competent, I believe. I don't know if it is as efficient as private medicine, but I am led to believe that the Army clinics (or any of the others) are not too involved with their patients as people. There are exceptions, of course. The Army has a superb medical support mechanism when we are at war. But Army dependents are not always pleased with their medical service, regardless of peace or war.

continued on next page

A New Pushcart

continued

What about an HMO or IPA? They seem to be well liked by many Americans. I have no reason to believe their physicians are less or more skillful than others. Purportedly, they provide more of their care out of a hospital than in. They are frequently reported as being more efficient and cost effective than fee-for-service medicine. Of course, many of these organizations still require a subsidy from the federal government in order to survive.

When you listen to Dr. Walter McClure (an expert on the economics of medicine), you will find that he sees medicine and the provision of physician services, as well as hospital services, as either becoming a regulated utility or becoming a system of care wherein the efficient provider of such services is rewarded and the inefficient provider is not. He believes that, at present, the inefficient provider is rewarded much more than

the efficient one. If he is accurate, the efficient provider needs our help if we are to avoid the development of a MUCO — a Medical Utilities Commission of Ohio. So do our patients.

If most of us are perceived as being

The OSMA will try to help you change your pushcart into a competitive truck, should you wish to do so.

counterparts of a Norman Rockwell illustration, why then the push to increase the regulation of our profession? The answer to that question lies in uncontrolled costs. Even if every physician's service was

free of charge (I will wash my mind out with soap for having had that thought) the cost of health care would remain uncontrolled.

Doubtless, a "new truck" will appear on our streets. As an association of physicians, the OSMA will be involved in the design of that "new truck" as much and as often as permitted. I believe that it is as unrealistic to try to block the development of these new trends as, ultimately, was the effort to prohibit the addition of yellow dye to margarine. In addition, the OSMA will try to help you change your pushcart into a competitive truck, should you wish to do so.

Oh yes, the OSMA is working on the set of bells to be placed on the "new truck." However, we are attempting to avoid the tune from becoming "On, Brave Old Army Team," or some other symbol of social regimentation of medicine.



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COLLEAGUES IN THE NEWS



JOSEPH A. ABRAM, JR., M.D.,

Hubbard, was named pediatric medical director for the Easter Seal Rehabilitation Center in Youngstown. Dr. Abram is the director of ambulatory services at Tod Babies and Children's Hospital in Youngstown.

WILLIAM ALTEMEIR, M.D.,

professor emeritus of surgery at the University of Cincinnati Medical Center, was awarded Henry Ford Hospital's first distinguished alumnus award. Dr. Altemeier is an authority on infections in surgical patients.

WILLIAM BACON, M.D.,

London, was elected vice-president of Peer Review Systems. Dr. Bacon is a general practitioner and has served as Madison County's coroner since 1953.

DUDLEY BRIGGS, M.D.,

Columbus, was elected chairman of the board of Peer Review Systems, Inc., a physician organization that provides services in health care review and data analysis. Also elected were **HARRY TOPOLOSKY, M.D.,** Grant Hospital, vice-chairman, and **WILLIAM T. PAUL, M.D.,** Mt. Carmel Hospital, treasurer.

Recently elected officers of the Medical Society of Suburban Community Hospital are: **ROBERT BRENNER, M.D.,** Beachwood, president; **JULIAN GORDON, M.D.,** Cleveland Heights, vice president; and **HAROLD MARS, M.D.,** Shaker Heights, treasurer.

KINGSBURY HEIPLE, M.D.,

Cleveland Heights, was named director of orthopedics at University Hospitals of Cleveland, and chairman of the department of orthopedics at Case Western Reserve University School of Medicine.

FREDERICK M. KAPETANSKY,

M.D., Columbus, was honored for his contributions to medical education by the American Academy of Ophthalmology. The award is given for accomplishments in presenting scientific papers, posters, exhibits and courses of instruction at the Academy's annual meetings and for development of educational programs.

FRANK H. MAYFIELD, M.D.,

Cincinnati neurosurgeon, is the first recipient of the Louis Nippert Award, given by the Elizabeth Gamble Deaconess Home Association. Dr. Mayfield developed the first intracranial aneurysm clip which enabled surgical care of aneurysms to become routine. Dr. Mayfield has been given the distinguished service awards of both the American Board of Neurological Surgery and the American Medical Association, was named honorary president of the World Federation of Neurological Surgeons, and named a Great Living Cincinnatian.

ROBERT H. MC MASTER, M.D.,

Cincinnati, was reelected president of the Ohio affiliate of the American Heart Association.

ISRAEL PENN, M.D.,

Cincinnati, was named chief of the surgical service of the Veterans Administration Medical Center.

JAMES PHILLIPS, M.D.,

Parma, was appointed to the board of trustees of Washington and Jefferson College in Washington, Pa., and to the Committee on Students of Case Western Reserve University's School of Medicine. Dr. Phillips is physician-in-chief of the Kaiser-Permanente Medical Center in Parma.



Dudley Briggs, M.D., Columbus . . . Peer Review Systems' new chairman of the board.



Frederick M. Kapetansky, M.D., Columbus . . . American Academy of Ophthalmology honoree.



Frank H. Mayfield, M.D., Cincinnati . . . first recipient of Louis Nippert Award.

Colleagues in the News . . .

continued

THOMAS ROESS, M.D., cardiologist, and **JOHN D. ALBERTSON, M.D.**, a family practitioner, were elected to the Lima Memorial Hospital board of directors.

RALPH M. SCOTT, M.D., Cincinnati, was named director of radiation medicine at Christ Hospital.

The American Committee for Shaare Zedek Hospital in Jerusalem will honor **EDWARD E. SIEGLER, M.D.**, chairman of the Cleveland Chapter, with its Distinguished Service Award. The award to Dr. Siegler is for his service not only to Shaare Zedek Hospital but also in recognition of his longstanding work on behalf of all local community organizations.

DONALD STEINBERG, M.D., Toledo, was the recipient of the Abe Axonovitz Memorial Award for outstanding service to the community, given annually by V.F.W. Post 6909. Dr. Steinberg, a surgeon, is the director of the Heme-Occult program at Riverside Hospital, and is presently doing research on breast cancer.

ROBERT E. TSCHANTZ, M.D., Canton, was elected president of the Greater Canton Chamber of Commerce.

Governor James A. Rhodes announced the appointment of **WILLIAM W. WELLS, M.D.**, Newark, and **GEORGE H. BONNELL, M.D.**, Worthington, to the advisory council to the Board of Nursing Education and Nurse Registration.

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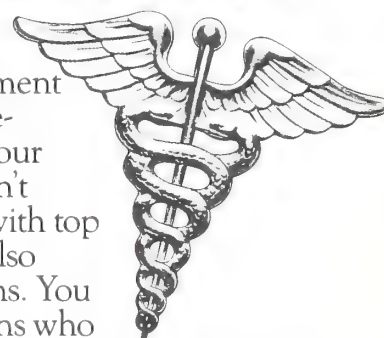
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edited by
Gina DiBlasio Cummins

The American College of Sports Medicine sets certification procedures

The American College of Sports Medicine has established certification procedures for Preventive and Rehabilitative Exercise Test Technologists, Exercise Specialists, Exercise Program Directors and Fitness Instructors. There are progressive expectations of knowledge base, skills and competencies for each of these categories.

The purpose of this program is twofold: 1) to increase competencies of those involved in preventive and rehabilitative exercise programs, and 2) establish means whereby the public consumer can recognize professional competence.

For further information contact: Martha Peterson, Continuing Education Coordinator, American College of Sports Medicine, 1440 Monroe St., Madison, Wisconsin 53706.

Controversial premenstrual syndrome may be overdiagnosed

Premenstrual syndrome (PMS) is getting more attention these days, not just in the medical world, but in the political and legal arenas as well.

"Premenstrual symptomatology, once termed 'milomina,' carried a favorable connotation because it suggested normal, ovulatory menstrual function. Now it has a negative meaning. 'Good' hormones have become 'raging' hormones, says Mona Shangold, M.D., who is associated with Cornell University Medical Center, Department of Obstetrics and Gynecology in New York City.

In England, PMS sufferers have been absolved of guilt after committing criminal acts, attributed to hormonal imbalances before menstruation. As a result, some feminists fear that *all* women will be labeled undependable because a few are unable to control their actions in these brief cyclical periods.

PMS, although real, remains vaguely defined, poorly understood, inadequately treated, and over-diagnosed, stresses Dr. Shangold. Unfortunately, it has become an excuse used by many women who have other causative pathology. Many who found it difficult to discuss symptoms that might reflect psychopathology find it easier to attribute their discomfort to raging hormones."

Reported symptoms fall into four main categories: anxiety, depression, increased appetite, and edema. Some women report all symptoms, while others notice only one or two. (PMS should be distinguished from dysmenorrhea, which is defined as menstrual pain and is caused by prostaglandin-induced uterine contractions.)

She says that although premenstrual discomfort can be extremely bothersome, most women have learned to function competently despite mood alterations or other discomforts. Among those who function well, many now are aware of PMS and are asking their physicians about the advisability of therapy. "I don't recommend any therapy for regularly menstruating women experiencing tolerable symptoms.

"I believe that PMS is not a disease, but rather an exaggeration of physiologic symptoms, which may be very uncomfortable and distressing. Serious research efforts must be directed toward finding a safe way to prevent or relieve these unpleasant symptoms. In the interim, PMS should not be blamed for other underlying psychopathology. Mature people always are responsible for their actions."



Combat surgery program planned

The Army's Academy of Health Sciences in San Antonio is putting together an "exportable" training program in combat surgery skills.

The emergency war surgery training program (EWSTP), when developed, will be sent to Army medical facilities in the United States and abroad to provide medical personnel, including physicians who are not surgeons, veterinarians, nurses and physician assistants, with information about life-saving surgical techniques they may have to use in time of combat.

Training in combat surgery currently is being provided in the combat casualty care course, specifically in the advanced trauma life support portion. However, that course is geared mainly to physicians.

The EWSTP, on the other hand, will encompass other personnel as well, such as nurses and physician assistants, who might be required to pitch in to help with the tremendous surgical loads expected from modern warfare, the press spokesman said.

Success rate of mastectomy alternatives debated

Are there therapeutic alternatives that give early breast cancer patients as good a chance for disease-free survival as does mastectomy?

The debate, reported in a recent issue of the *Journal of the American Medical Association*, is over whether conservative surgery, followed by radiation therapy is as effective as the conventional modified or radical mastectomy. The newer conservative techniques include removing the cancerous lump, and segmental resection or quadrantectomy, which involves removing more of the breast. In contrast, the conventional modified radical (or total) mastectomy involves removal of the entire breast and one of the underlying chest muscles, while a radical mastectomy requires removal of both chest muscles as well as the axillary lymph nodes. The nodes are removed so that they may be examined for the presence of cancer.

Data from five studies carried out over periods of 10 to 20 years in France, Canada and the United States provide evidence that some form of local excision with radiation therapy (to the breast and sometimes the axillary lymph nodes) is equivalent to mastectomy in preventing disease recurrence and prolonging survival and is superior in cosmetic results. Survival rates of 83% at five years and 71% at 10 years were reported by Roy Clark, M.D., radiation oncologist at the Princess Margaret Hospital, Toronto, comparable to rates reported for radical surgery.

A number of physicians still believe that mastectomy gives superior results for most patients. Jerome Urban, M.D., attending surgeon in the Breast Service at Memorial Sloan-Kettering Cancer Center, New York, says lumpectomy and radiation therapy are a reasonable choice for patients who have small tumors and no sign of cancer in the axillary lymph nodes. For patients with larger tumors and nodal involvement, though, some type of mastectomy is indicated, he said.

There is some agreement in the debate that conservative surgery and radiation therapy could be substituted for mastectomy in treatment centers

where a sophisticated medical team, consisting of a surgeon, pathologist, oncologist and radiotherapist, is available. "If a patient cannot go to a center with a knowledgeable, dedicated team, she is better off having a mastectomy," said Jay R. Harris, M.D., clinical director of the Joint Center.

In a study at Long Island Jewish-Hillside Medical Center, New Hyde Park, N.Y., Leslie Wise, M.D., chairman of surgery, found a major difference between the self-images of 21 lumpectomy patients and 46

mastectomy patients. Women undergoing lumpectomy, the study revealed, showed less decrease in feelings of femininity and attractiveness and were less self-conscious than mastectomy patients. The investigators also found that lumpectomy patients received more emotional support than did mastectomy patients, possibly because they were more open about their surgery and more comfortable in talking about it with their husbands, friends and physicians.

Tune in . . .

Cincinnati's "Call the Doctor" show features new host/format

Cincinnati Academy of Medicine's popular "Call the Doctor" show returns to television with a new moderator, and a modified format.

John R. Loughrey, M.D., an internist and gastroenterologist, will host the half-hour program, replacing Albert E. Thielan, M.D., the original host of what was the first, and still remains the longest running medical panel program on television. Dr. Thielan retired from participation with the show early this past summer, after 22 years.

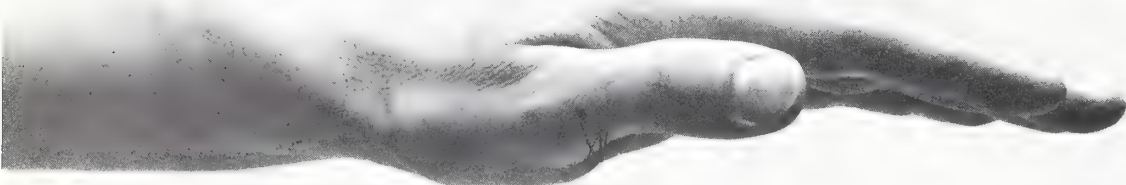
The new "Call the Doctor" program will be half an hour, and will have Dr. Loughrey and his weekly specialist guest fielding viewers' questions, which are phoned in live throughout the program. This differs from the original hour-long format which featured a panel of four medical guests.

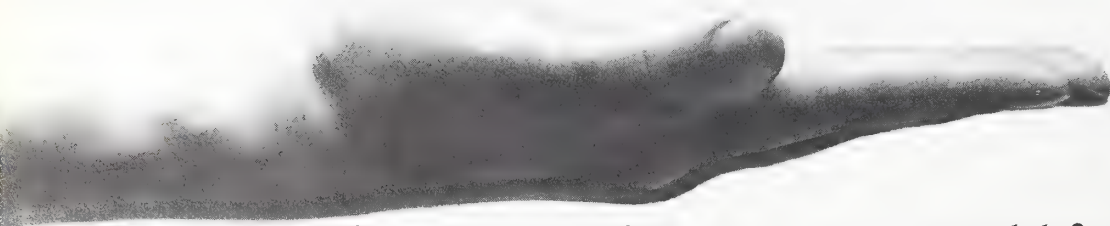
A member of the Academy of Medicine of Cincinnati since 1977, Dr. Loughrey was elected to the American Society of Internal Medicine and to the American College of Physicians. He is on the attending staffs of Good Samaritan Hospital, Providence Hospital, and St. Francis-St. George Hospital.



John Loughrey, M.D., moderator, "Call the Doctor," WCPO/TV, Cincinnati, Ohio

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In the Interim . . .

The report of the 1982 AMA Interim Business Meeting

By Oscar Clarke, M.D., and C. Douglass Ford, M.D.

Chairman and Cochairman, Ohio Delegation to the AMA

This report covers some of the important issues voted on by the Ohio Delegation at the 1982 Interim Business meeting of the American Medical Association in Miami Beach, Florida, December 5-8, 1982.

There were 54 reports and 84 resolutions considered by the AMA House of Delegates. One of the resolutions was introduced by the Ohio Delegation.

PROTOCOL FOR EMERGENCY MEDICAL SERVICES PERSONNEL

The Ohio resolution on Protocol for Emergency Medical Services Personnel was referred to the AMA Commission on Emergency Medical Service for a report back at the 1983 Annual Meeting. The resolution asks the AMA to establish a protocol for emergency medical personnel who respond to the scene of an emergency where a physician may already be administering care. AMA's Commission on Emergency Medical Services is studying this issue in depth with plans for a final report to the House of Delegates in June, 1984. In view of the urgency indicated by some individuals, however, a status report on this study at the 1983 Annual Meeting is appropriate.

The Ohio Delegation unanimously supported referral.

LEGAL DRINKING AGE

The AMA House of Delegates

adopted a resolution recommending that the AMA encourage states to establish the legal drinking age of 21 in their state. The testimony before the reference committee was overwhelmingly in support of this resolution. Several references provided statistical evidence and solid reasons to adopt the resolution.

The Ohio Delegation unanimously supported adoption.

STATE AND NATIONAL LEGISLATION HEARINGS REGARDING LIFE SUPPORT MEASURES FOR SEVERELY DEFECTIVE INFANTS

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association support legislative and regulatory actions concerning the care of severely deformed infants and the terminally ill which are consistent with Judicial Council Opinions 2.10 Quality of Life and 2.11 Terminal Illness, and be it further

RESOLVED, That AMA oppose legislative and regulatory actions that mandate conduct contrary to Judicial Council Opinions 2.10 Quality of Life and 2.11 Terminal Illness."

The resolution refers to HR-6492 and asks that AMA oppose this bill as an intrusion into the practice of medicine and to monitor and oppose other similar legislative and regulatory actions. In testimony before the

reference committee a member of the AMA Council on Legislation described AMA opposition to HR-6492 and provided a copy of the AMA statement in opposition. This statement bases AMA's opposition on Judicial Council Opinion 2.10, entitled Quality of Life. This opinion is contained in *Current Opinions of the Judicial Council — 1982*.

The Ohio Delegation supported adoption.

PEER REVIEW IMPROVEMENT ACT OF 1982

The AMA House of Delegates adopted an amended Council on Medical Service report on the above subject. The Council on Medical Service report describes the new peer review program (UQCPRO) enacted by PL 97-248 and points out unresolved questions, the possibilities for state medical association involvement, and implications of the program for medicine. The Reference Committee recommended that interested medical societies as well as the AMA should continue to monitor the implementation of the new law and take a leadership role in establishing statewide peer review mechanisms.

The Ohio Delegation unanimously supported adoption.

LIABILITY RELATING TO VACCINE-RELATED INJURIES

The AMA House of Delegates
continued on page 8

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In the Interim . . .

continued

adopted the following substitute resolution:

"RESOLVED, That the American Medical Association support appropriate state and federal legislation which would hold physicians harmless for adverse reactions to immunizations required by state or federal law for prevention of communicable diseases, providing the immunizing agents are administered without negligence; and be it further

RESOLVED, That the American Medical Association support appropriate state and federal legislation which would hold manufacturers harmless for adverse reactions to immunizations required by state or federal law for prevention of communicable diseases, providing the immunizing agents are manufactured without negligence."

The Ohio Delegation supported adoption.

HR 4961 — PROPOSED REGULATIONS

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association oppose vigorously regulations under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) which would:

1. Interfere with and/or redefine the practice of medicine;
2. Substitute hourly wages or annual salaries for present reimbursement mechanisms for physicians' services to patients;
3. Base physician reimbursement on any system which does not give recognition to skill, knowledge, time and effort; or
4. Otherwise impinge significantly upon the practice of medicine.

Such opposition, as required and appropriate, shall be expressed through action in Congress, with the Administration, and in the Courts.

The Ohio Delegation unanimously supported adoption.

THE INDEPENDENT PRACTICE OF MEDICINE BY "NURSE PRACTITIONERS"

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association, in the public interest, urge state medical associations to oppose enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches."

The Ohio Delegation supported adoption.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS — MEDICAL STAFF

The AMA House of Delegates adopted the following reaffirmation of policy in the form of three recommendations:

Recommendation 1: "RESOLVED, That it is the policy of the American Medical Association that the objective of hospitals accreditation is primarily to evaluate the quality of patient care, to provide recommendations for remedying deficiencies and improving the quality of patient care, and to withhold accreditation from those institutions which do not meet an acceptable standard of patient care; and be it further

RESOLVED, That the AMA oppose accreditation requirements which impose rigid, uniform, mandatory administrative procedures, methods of operation, nomenclature, or forms of organization for the hospital, its governing board, attending staff and committees; and be it further

RESOLVED, That the AMA recognize that excellence in patient care is more easily attainable when the accreditation process is flexible and is concerned with evaluating the quality of hospital service and not the administrative procedures, or form of organizations used to provide patient care; and be it further

RESOLVED, That the Board of Trustees, in its discretion, give the AMA Commissioners to the Joint Commission on Accreditation of Hospitals appropriate guidance for

implementing this resolution."

Recommendation 2: "RESOLVED, That the AMA Commissioners to the JCAH be commended for their efforts to develop methods of preserving appropriate physician involvement in the maintenance of quality patient care throughout the process of revising the "Accreditation Manual for Hospitals."

Recommendation 3: "RESOLVED, That proposed revisions to the JCAH "Accreditation Manual for Hospitals" ("AMH") be widely disseminated for comment and that the AMA inform physicians of subsequent revisions in the AMH through appropriate publications."

The Ohio Delegation supported adoption.

HEALTH POLICY AGENDA — NATIONAL HEALTH POLICY

The AMA House of Delegates adopted a Board of Trustees report and an amended resolution on the above mentioned subject. The project is expected to be of at least three years duration. Multi-organizational units will be formed to actually conduct the analysis and develop and refine the specific methodology that will be used in the project's initial phases. Organizationally, the project will be composed by a steering committee, an advisory committee and six work groups. The American Medical Association is to forward timely reports of the health policy agenda steering committee to all state medical societies, AMA Delegates and AMA Alternate Delegates for review and input. The purpose of the project is to provide a broad-based outline of major concerns for the health sector, including both private and public elements, for the foreseeable future. This conceptual and philosophical framework will be consistent over a multiple-year period as the basis for specific action plans responding to the social, economic, scientific, educational, and political circumstances that evolve from year to year. The National Health Policy will give the AMA and others in the health

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In the Interim . . .

continued

sector the opportunity to abandon the traditional, year-by-year, piecemeal development of policy that responds only to pressures of the moment.

The Ohio Delegation supported action.

SIZE AND COMPOSITION OF THE HOUSE OF DELEGATES

The AMA House of Delegates adopted an amended Board of Trustees report that included the following recommendations:

Recommendation 1: "That the AMA continue to strengthen its position as the universal organization seeking to represent all of medicine with policies developed in a forum that provides for the broadest representation of views."

Recommendation 2: "That the current mechanism for reviewing specialty society applicants for representation in the House of Delegates be maintained, and that specialty societies accepted into the House of Delegates continue to meet the criteria that supported their initial acceptance."

Recommendation 3: "That AMA urge all states that gain additional seats in the House of Delegates on the basis of increased student and/or resident members in their societies, to select student and/or residents to assume some of those seats."

Recommendation 4: "That the AMA invite the American Hospital Association and the American Dental Association each to send an official observer to meetings of the House of Delegates, and that the privilege of the floor should be by invitation."

The Ohio Delegation supported adoption.

SPECIAL SECTION FOR HOSPITAL MEDICAL STAFFS

The AMA House of Delegates adopted a report of the Study Committee on Hospital Medical Staffs that included the following recommendations:

Recommendation 1: "That the House of Delegates approve the establishment of a Hospital Medical Staffs Section of the AMA."

Recommendation 2: "That the Hospital Medical Staffs Section shall have a

governing council including one delegate and alternate delegate to the House of Delegates."

Recommendation 3: "That representatives to the Hospital Medical Staffs Section shall be members of the AMA and be encouraged to be members of the state or county medical societies, nominated and elected by the active voting physician members of the medical staff, and must have clinical privileges at the institution they represent."

Initially, representatives to the section may be selected by the elected physician leadership of the medical staff; however, after July 1, 1984, proof of nomination and election by members of the active voting physician medical staff shall be required."

Recommendation 4: "That the Hospital Medical Staffs Section shall be organized as an open assembly to which each hospital medical staff would be eligible to send one elected representative. All state and county medical societies are urged to work closely with medical staffs in their areas to facilitate participation in the Section. A possible model would be a Hospital Medical Staff Section at the Annual Meeting of each State House of Delegates and a Hospital Staff Liaison Committee in each county medical society, where appropriate."

Recommendation 5: "That AMA offer assistance and support to state and county efforts to relate to hospital medical staffs; and, that the Board of Trustees report on the progress and the cost of the Hospital Medical Staff Section at appropriate times."

The Ohio Delegation supported adoption.

DUES EXEMPTION

The AMA House of Delegates adopted a Board of Trustees report stating the following:

"Based on the Association's study of the philosophical, structural, and administrative issues, as well as on a review of possible options, the Board recommends:

1. Alteration of the criteria for dues exemption, effective with the 1983 membership year, as follows:

- a. Grant exemption based on financial hardship and/or disability;
 - b. Grant exemption to members aged 65 and retired (work 20 hours or less per week);
 - c. Grant exemption to members aged 70 regardless of retirement.
2. Installation of a half-price subscription rate for *American Medical News* for exempt members. Currently, the *Journal of the AMA* and specialty journal are offered to exempt members at half price, but *AM News* is distributed at no charge. The half-price charge for *AM News* would offset a portion of the expense of implementing the new criteria."

The Ohio Delegation unanimously supported adoption.

A listing, by title, of some of the reports follows. If you would like a copy of any or all of these reports, please contact the OSMA office.

1. Environmental Protection Agency
2. Competition in Medicine: An AMA Action Plan
3. Initial Report of the National Commission on Nursing
4. The Diminishing Family and Its Impact on Health — Progress Report
5. Certificate of Need Programs: A Status Report
6. Block Grants: A Status Report
7. Access to Care by Medicaid Beneficiaries
8. Status Report on Health Maintenance Organizations
9. Calcium Channel Blocking Agents
10. Physician Mortality and Suicide: Results and Implications of the AMA-APA Pilot Study
11. Automobile-Related Injuries: Components, Trends, Prevention
12. AMA Involvement in Prevention and Treatment of Child Abuse and Neglect
13. Pneumococcal, Influenza and Hepatitis-B Vaccine

Oscar Clarke, M.D., Gallipolis, is Chairman of the OSMA Delegation to the AMA. C. Douglass Ford, M.D., Toledo, is President of the OSMA.



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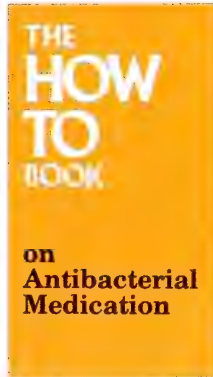
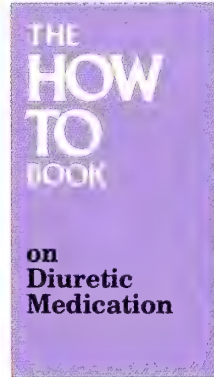
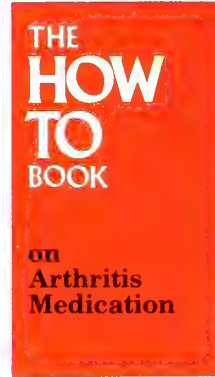
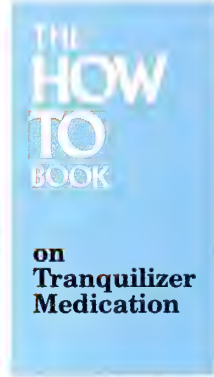
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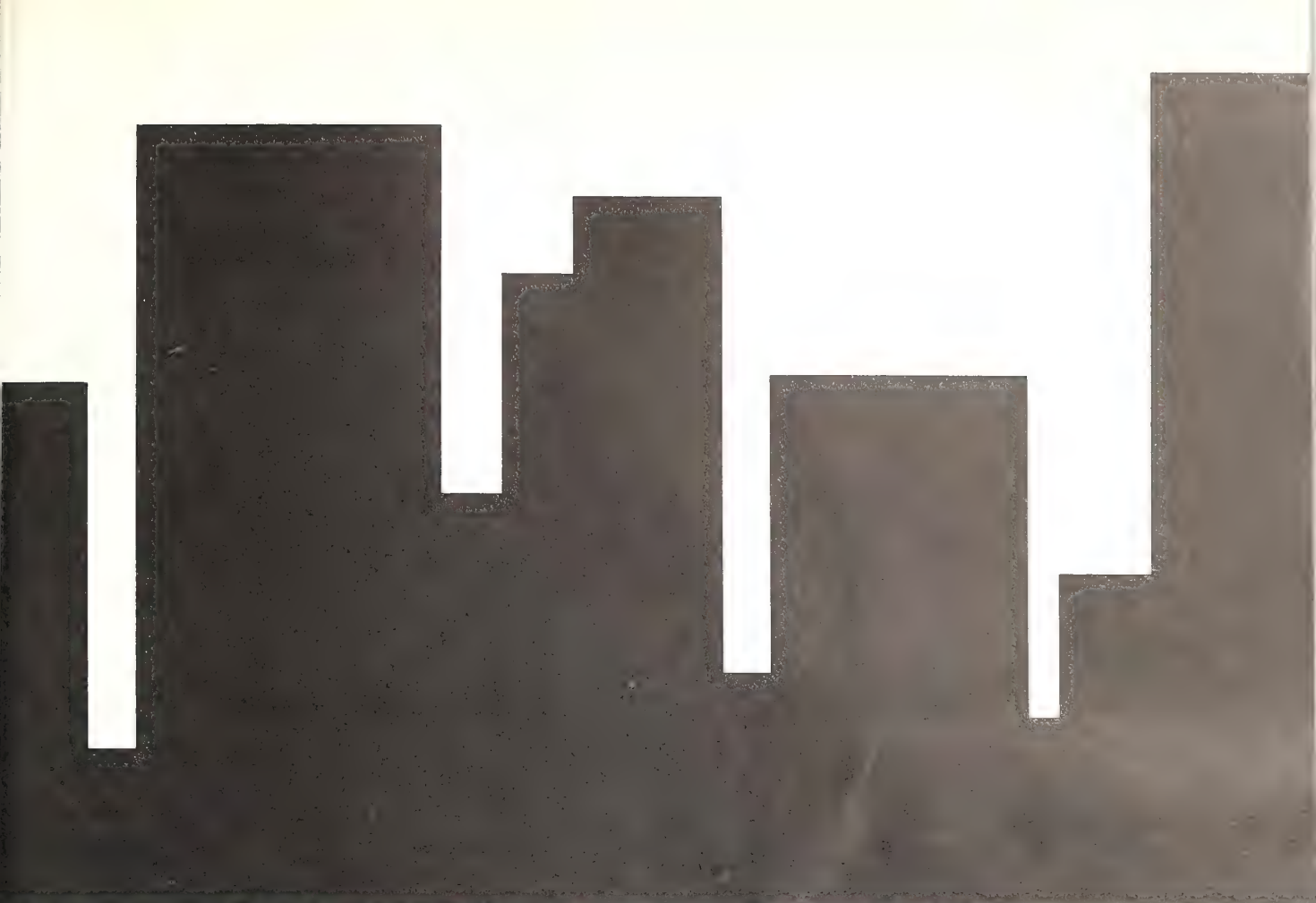
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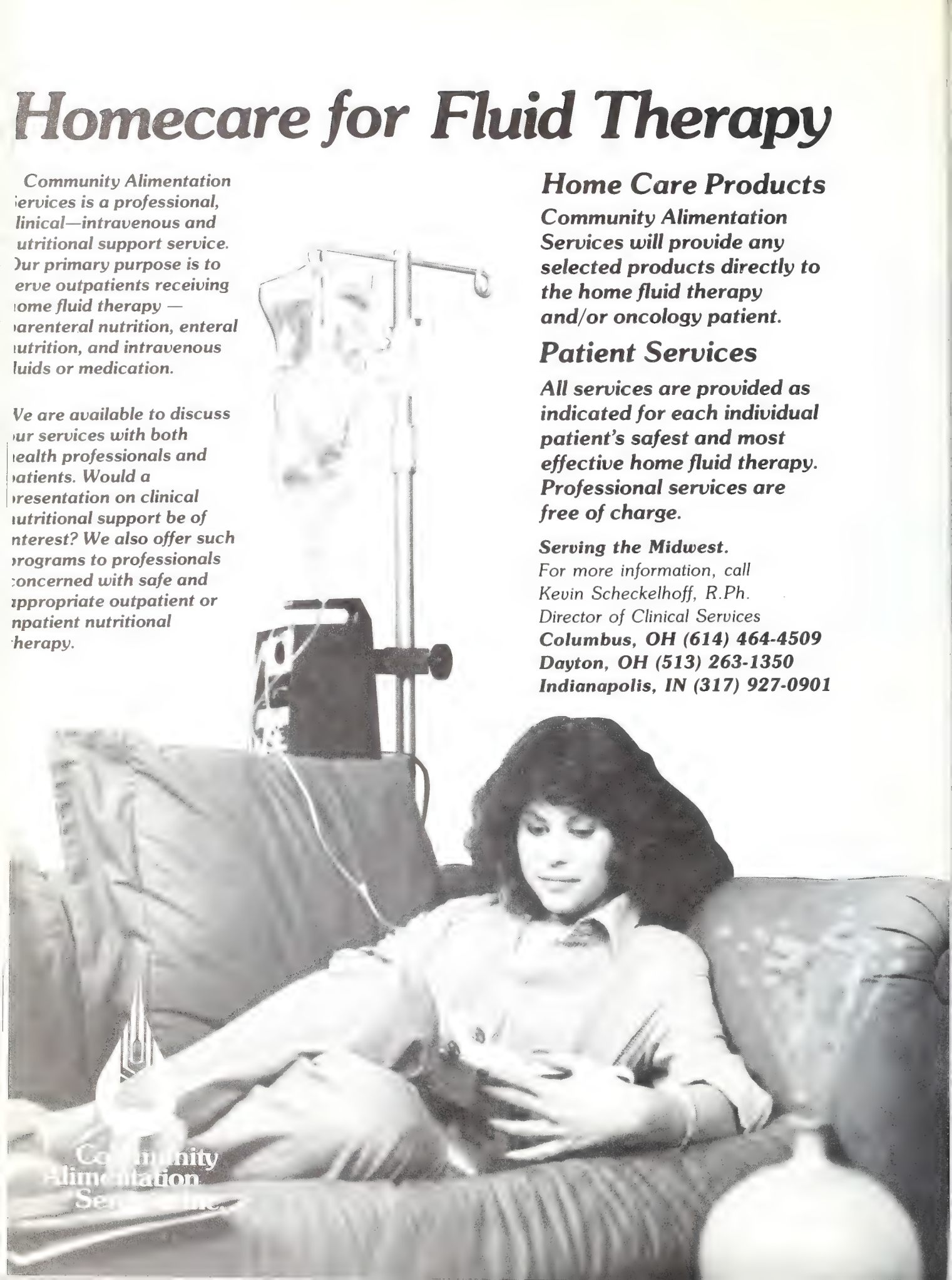
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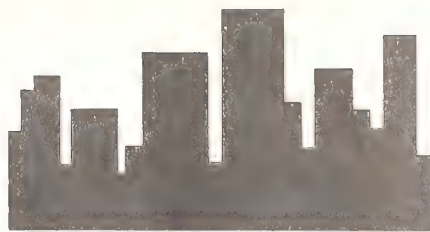
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Competition and Marketing A physician's guide

Understanding Competition

By George J. Nielson

In the domain of clinical practice, a practice manager must understand how the practice of medicine operates — which factors in its environment affect its operation, and how those processes work. The manager must then predict how these characteristics are likely to change in the future. On the basis of this knowledge, he or she may then select and implement strategies which are expected to maintain or improve practice viability in the future.

While developing an understanding of the practice and its environment, the manager will encounter a number of variables that may be used to describe different aspects of practice viability. Some will be descriptions of the practice operation. "Cost per visit," "proportion of accounts receivable recovered," "practice income," and "visits per patient episode of care" are only a few examples. Others will be descriptions of activity at the practice's marketplace: its local service area. "Physicians per capita," "market share per practice organization," "visits per capita," "proportion of patients from a specific geographic element of the service area," and "health care dollars per capita," are examples of this type of variable. Still others will describe the operations that give rise to patient demand for care, the availability of basic practice resources or the availability of capital. Rather than attempting to create one all-encompassing model of the practice and its environment, the prudent manager will begin by focusing on the identification of those key variables

that describe the most significant elements of practice performance. Of course, different types of practice and different types of practice organizations reflect different performance goals. But five goals, relevant to any practice, are readily identified. These are:

- To maintain a specified patient load
- To provide quality care for each patient
- To minimize the unit cost of services provided to each patient
- To provide services at a unit price that is competitive at the local marketplace, and
- To achieve a desired level of income from the practice.

Future performance of a practice will depend on how well its manager has controlled environmental variables.

The attainment of performance goals presumes that there are management mechanisms at work, and future performance of a practice will again depend on how well the manager has observed and controlled the variables at work in the environment.

There are several ways that change in a practice may take place. For example, a change in practice performance may result from

management's deliberate change of the practice organization's policies or it may arise from deliberate intervention in processes of the environment. For example, a change in marketing strategy may result in practice performance change.

A change also may be the direct result from changes in the environment. Such environmental changes fall into four categories:

- Changes in population which determines the demand for care
- Changes in the social policy governing the maintenance of public health
- Changes that are the result of competition in the local service area, or
- Changes in the availability of basic resources, including capital, that are required in order to operate the practice

In these cases management must quickly assess the impact and cause of the change, in order to determine what can be done to maintain the practice organization's performance. Since surprises arising from environmental change obviously are to be avoided, the wise practice manager will attempt to forecast these impending changes as far ahead as possible.

"Strategic practice management" is, in fact, the process of anticipating future changes, identifying their potential impact on the practice, and selecting strategies which are expected to maintain performance in the face of change.

The principal product of a physician's practice is the "visit": the

continued on next page

Understanding Competition

continued

gathering together of a physician, a patient, his clinical record, and supporting resources, all at an appointed place and time. Here we will consider a "primary care" practice that deals directly with the public, rather than a "subspecialty" practice that receives its patients by referral from other physicians. The "supply" of visits resulting from a solo practice is equal to the number of hours (per unit time) that the physician is willing to practice, divided by the average length of time required for a visit. The visit supply of a multiple physician practice is, of course, the sum of the visit supply of each physician.

On the demand side of the marketplace, the natural process of disease occurrence, operating on a population base, gives rise to a population of patients. Within any geographic service area, this patient population is served by one or more practice organizations. When two or more practices are competing in a service area, each is observed to capture a market share (ie, a proportion of the total patients in the service area). Each patient's need for visits is determined by the standards of clinical practice, as implemented by the physician. At the outset of an episode of illness, each patient receives a "triage" visit that establishes a working diagnosis, diagnostic and therapeutic goals, and a visit pattern for the remainder of the episode of illness. The "worried well" are reassured, and others will be seen at appropriate intervals throughout their episode of illness. The frequency of visits during an episode of care varies widely from patient to patient, but is observed to correlate with "disease or condition" and patient attributes such as "age." The population over 65 years of age, for example, may be expected to need several times as many visits as the young adult population suffering from similar clinical conditions. Good clinical practice suggests that the physician should serve the patient, rather than simply providing "visits," so as to provide the element of

continuity for each patient's care.

The dynamics, or variation over the course of time, of both the population and the illness occurrence process are predictable. Hence, the patient load is predictable in a service area of at least moderate population size. Applying normative standards for "visits per patient," adjusted for type of illness and population characteristics such as age, yields forecasts of visits that are likely to be required for the population base.

Once the practice manager has completed a forecast of patient activity in his service area and identified the visit activity that is expected to arise from his market share, he may compare his forecast of visit supply to the anticipated demand. If the practice has no competition, and demand exceeds the supply of visits, he is operating in the best, and rarest, of all situations. If supply is outstripping

The market share of a practice may be increased either by improving the image of the practice's care, or by reducing the price of care.

demand in his service area, he must identify strategies for increasing his market share (if there is competition) or for the reduction of his future supply of visits.

Basic strategies for increasing the market share stem from the fact that the performance of a product at a competitive marketplace is dependent on its quality (whether measurable or perceived) and on its price. Thus, the market share of a practice may be increased either by improving the image of the practice's care (in terms of its quality or continuity), or by

reducing the price of care. Today, in this regard, patients, employers and insurers are all rapidly becoming more cost conscious.

If the practice reduces its unit visit price, it may erode the practice income. Income, of course, is equal to revenue less expenses. The practice revenue is equal to the product of the visits delivered times the unit visit price. The practice expenses are equal to the cost of the visits delivered plus the cost of maintaining a capability for increased visit supply. Serving the performance goal of efficiency (minimizing the cost of a visit) is always appropriate, and implies careful attention to the management of the practice's capacity to produce visits. All else being equal, the efficient practice is in the best position to compete on the basis of visit price.

The better a practice is able to describe the population that it serves, the better it is able to anticipate its patient and visit loads and, hence, to manage its visit capacity. Thus, it is generally easier to be efficient in the competitive environment when the service area population is "enrolled" for care by the practice. This is one incentive for practice management to consider the HMO, IPA and PPO types of organizational structure. Gaining economies of scale in both the purchasing of basic resources and the cost of maintaining management functions, also a powerful tool in the reduction of visit cost, is an incentive for practice growth, whether this growth is accomplished at a central practice location or through a geographic expansion of centrally managed practice sites.

But minimizing the price of a visit is not enough. Consumers, employers and insurers are all concerned with the cost that they must bear for an episode of care. Typically this will involve several visits occurring in a time frame established by the physician. As the "first-line" manager of the health care process, it is the practicing physician's responsibility to assure that everything is done for each patient that should be

done. It is also his responsibility to assure that nothing is done for a patient that should not be done. His thoughtful attention to both of these responsibilities in the planning and execution of care for each episode of illness has been shown, in controlled settings, to reduce the average cost of an episode of care without compromising either the patient's clinical outcome or his satisfaction with the health care process.

Thus, an important aspect of strategic practice management is to assure that the practicing physician understands and executes his responsibility to both his patient and the practice organization, and that goals of patient care and organizational performance do not come into conflict during the course of his management of the health care delivery process. This is, perhaps, a

compelling argument for the use of (nonpracticing) physician managers in the clinical care setting, since their training in the patient care process helps to assure a minimum of goal

**All else being equal,
the efficient practice
is in the best
position to compete
on the basis of visit
price.**

conflicts in the operation of the practice organization.

In summary, we see that the five key variables defining practice performance are intimately interrelated, and that the management

of their values requires attention to both the environment of the practice and the structure and function of its organization. Thus, in the face of inevitable environmental change, strategic practice management is dynamic and spans the continuum of management planning and control.

Mr. Nielson is a consultant whose area of specialty is management planning and control. For the past fifteen years his attention has focused on the health care industry, and he has served as a Senior Health Care Systems Planner with Battelle Laboratories. He has served as consultant to the Ohio State Medical Association since November 1982.

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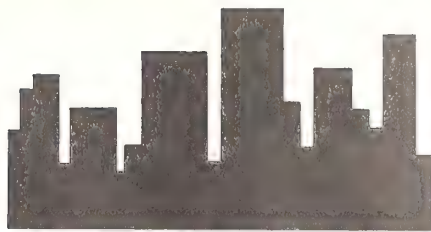
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Competition and Marketing A physician's guide

Physician Supply

What is the Competition?

By Thomas A. Helmrath, M.D. and Michael Tootell

In 1970, there was a perception that unless a concerted action was taken by 1980, Ohio would have a marked shortage of physicians for the state's anticipated population. This shortfall of physicians was projected to be mainly in the primary care disciplines with a general physician maldistribution by regions as an additional overlying factor. The Ohio Board of Regents, the agency responsible for planning and coordination of medical education in the state, retained consultants in 1970 and 1972 to advise them on strategies for resolving this anticipated crisis in physician manpower.^(1,2) In both reports, residency expansion and upgrading of quality were identified as important components of the ultimate solution along with a significant increase in the class size at the four established medical schools. No strong case was made for additional medical schools at that time, though there was support for studying the possibility of one in the northeast region of the state.

The purpose of this paper is to compare the physician manpower findings of 1970 with 1982 and to

determine if the initiatives taken in 1970 were successful in resolving the anticipated crisis.

PHYSICIAN MANPOWER — 1970

In 1970, Ohio had a population of approximately 10,688,000 people and 11,998 licensed physicians of which 1,801 were house officers.^(2,3) As can be seen in Table 1, 462 students entered medical school while 337 graduated that spring. Using criteria from three separate national studies, the consultants concluded that Ohio should have graduated 543 physicians to meet the state's manpower needs.⁽¹⁾ Of the 943 intern positions available, 67% were filled and only 139 of the 375 American- and Canadian-trained interns graduated came from Ohio schools.^(1,2) Though 83% of the residency positions were filled, only 53%, or 1,121, were American or Canadian medical school graduates.

Using physician data from 1971, Lee estimated that Ohio needed 2,184 additional physicians in order to have an adequate supply for the population.⁽³⁾ In addition, he estimated that another 1,573

physicians would be lost from practice between 1971 to 1980.

The four established medical schools responded to the growing pressure at that time for expansion by indicating their willingness to significantly increase the entering class positions. From the data in Table 2, physician output was projected to increase 164% by 1980 and in addition, Case Western Reserve University and The Ohio State University indicated that further expansion was possible with additions to their physical plants.

None of the consultant studies projected a state-supported pro forma operating budget for a total enrollment of 3,000 to 3,600 medical students, nor indicated what statewide policies should be after the physician shortage was resolved.

PHYSICIAN MANPOWER — 1982

In Table 3 are the current data on Ohio's population and physician manpower. It is evident that the total population has increased only about 120,000 people. While there has been a shift toward an older population, in the aggregate this shift does not

continued on next page

compensate for the absent to small growth in the other age categories. There were projections made in late 1974 that predicted an Ohio population of 11.6 million by 1980 and 12.2 million by 1985.⁽⁴⁾

Ohio now has seven accredited medical schools: five public and one private allopathic and one public osteopathic. These seven schools graduated 896 physicians in 1982 and enrolled 1,025 students for the class of 1986. This represents a 265% increase in graduates and an increase of 221% in entering class size when compared to 1970 data. Of the 896 new physicians, 724 graduated from the four schools present in 1970, while the number of medical students has increased 229% when compared to the 1970 medical student census.

There are currently 3,625 resident training positions in the state. Family Medicine has experienced the largest growth in residency filled positions, expanding from five first-year positions in 1970 to 141 in 1982.⁽⁵⁾

As of January 8, 1983, there are 17,793 licensed physicians in Ohio, an increase of 48% since 1970. A breakdown by specialty category can be found on Table 3, and when compared to 1970 findings, there has been a 32% increase in primary care,

TABLE 1.
PHYSICIAN MANPOWER
STATUS — 1970

Ohio Population	10,688,000
Medical School Output	
Schools	4
Graduates	337
Entering Class	462
Total Enrollment	1580
Internships and Residency	
Internships —	
Total positions	943
Filled positions	634
Residency —	
Total positions	2549
Filled positions	2109
Practicing Physicians	10,197
Primary Care	4,703
Medical Specialty	601
Surgical Specialty	3,010
Other	1,883

Data Source: References 1, 2 and 3.

TABLE 2.
MEDICAL SCHOOL ACTUAL AND PROJECTED
ENTERING CLASS — 1970

	1970	1975*	1980*
University of Cincinnati	110	192	192
Ohio State University	216	227	264
Medical College of Ohio at Toledo	32	64	150
Case Western Reserve University	104	150	150
Totals	462	733	756

*Projected entering class.

Data Source: Reference 1.

69% increase in surgical disciplines, and over 300% increase in medical specialists.

Using only one federal criteria for physician manpower shortage, a ratio of one primary care physician per 3,500 population, we found 16 Ohio counties had at least a fractional shortage, which in the aggregate, required an additional 34.6 physicians. On closer examination, only four counties require more than two physicians to reach the standard. Some of these shortages are artificial since the physician's practice is located on one side of a county line and their patient population on the other with a very short distance between them. If an adequacy ratio of 1:2,500 is used, then there are 48 counties with a shortage, and a requirement for 184 additional primary care physicians. It is recognized that there are other federal criteria for designating a shortage area and that multiple opinions exist on defining what constitutes an adequate supply of physicians. A shortage of several hundred is quite an improvement over the 2,184 physicians in 1970.

REPLACEMENT NEEDS

As part of the GMENAC Study, a separation rate by age groups was developed that accounted for death, retirement, and departures from practice of all types.⁽⁶⁾ If these separation rates are applied to Ohio's 1983 physician population, it is possible to get an estimate of how many physicians would be needed for Ohio to maintain a given number of physicians. For this calculation, we

used the January 1, 1983 physician census and on Table 4 are the findings displayed by specialty, which indicate a total replacement of 334 per year, given no change in any underlying assumptions. When a comparison of replacement by discipline is made against outputs of the state residencies, as found in Table 5, it is clear that Ohio can safely maintain a steady state without recruiting physicians from other states or countries.

TABLE 3.
PHYSICIAN MANPOWER
STATUS — 1983

Total population	10,800,000
Medical School Output 1982	
Schools	N = 7
Graduates	896
Entering Class	1025
Total Enrollments	3629
Residents and Fellows	
Filled positions	3625
Filled primary care positions ⁽¹⁾	1476
(1)	
Practicing physicians ⁽²⁾	
Medical Specialty	1915
Surgical Specialty	5073
Other	4618

(1) Pediatrics, Internal Medicine, Family Practice.

(2) Includes house officers with a license.

Data Source: Ohio Department of Development, Ohio Board of Regents, Ohio Department of Health, Ohio Medical License Board

TABLE 4.
PHYSICIAN SHORT SUPPLY AND
REPLACEMENT REQUIREMENTS — 1982

SUMMARY

Since 1970, efforts to expand and upgrade the quality of the state's physician residency training programs have been very successful, as has been the increase in physicians graduating from the state's older established medical schools. In addition, three new medical schools have graduated at least two classes of students and are or will soon be at maximum entering class size. In the spring of 1984, 1,000 physicians will graduate from Ohio's schools, and enter residency programs. If there is no change in the number or mix of residency positions, there will be sufficient numbers of residents finishing training to fill all vacant practice opportunities in the state. If there are physician shortage areas, it will not be due to insufficient production by the state's medical schools and/or resident training programs.

Projecting physician manpower needs for a population five years into the future is a hazardous undertaking because sociopolitical and economic factors influence the process and themselves can change rapidly.

The Health Affairs Office of the Ohio Board of Regents has developed an extensive physician manpower data base and a simulation model that incorporates economic and social factors to assist the agency in planning the state's physician production for future years.

REFERENCES:

- (1) *Meeting Ohio's Needs for M.D.'s Through 1980 and Beyond*. The Academy for Educational Development, Inc. New York. December 31, 1970.
- (2) Lee, Philip: *Medical Study Report*. Consultant Report. The Ohio Board of Regents, Columbus, Ohio. June 30, 1972.
- (3) Lee, Edgar: *Physician Demography in Ohio — 1971*. Consultant Report. The Ohio Board of Regents, Columbus, Ohio. December 29, 1972.
- (4) *Health Manpower Reference: The Supply of Health Manpower*. 1970. Profiles and Projections to 1990.

Short Supply

	Primary Care 1:3500	Standard 1:2500
Counties failing standard	16	48
Distribution of counties		
Physicians needed/county		
0 - 1.0	7	6
1.1 - 2.0	5	8
2.1 - 5.0	3	24
5.0	1	10
Total physicians required	36	184

Physician Replacement⁽¹⁾

Total required	334
Primary Care	116
Family Practice	61
Pediatrics	19
Internal Medicine	36
Non-Primary Care	218

(1) GMENAC separation ratio calculation

TABLE 5.
RESIDENCY DATA: 1980-1981

Primary Care	PGY1	Total Residents	Available to ⁽¹⁾ Enter Practice
Pediatrics	103	277	153
Internal Medicine	212	754	406
Family Practice	220 ⁽²⁾	445 ⁽²⁾	189 ⁽³⁾
OB/GYN	47	212	56
Psychiatry	30	178	66
General Surgery and Surgical Specialties	138	912	354
Other Specialties ⁽⁴⁾	112	445	105

- (1) PGY3 + Senior Fellows
- (2) Includes 116 Osteopathic Interns
- (3) All PGY3 + 93 Osteopathic Interns
- (4) Pathology, Radiology, Physical Medicine, Emergency Medicine, etc.

Data Source: Ohio Board of Regents Residency Inventory

- DHEW Publication NO. (HRS) 75-38. December 1974.
- (5) Williams, Tennyson: Personal Communication, December 1982.
- (6) Report of the Graduate Medical Education National Advisory Committee, Volume II. p. 264. DHHS Publication No. (HRS) 81-652. September 30, 1980.

Thomas A. Helmuth, M.D., Columbus, is Vice Chancellor for Health Affairs, Ohio Board of Regents. Michael Tootell, Columbus, is Administer, Health Planning and Analysis, Ohio Board of Regents.

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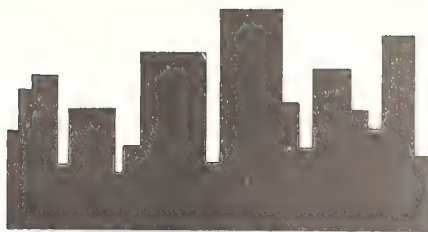
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Competition and Marketing
A physician's guide

The Newest System of Alternate Care

By Robert Holcomb

Health care's newest way to shrink the excess capacity* of hospitals is the Preferred Provider Organization (PPO).

Interstudy's* nationwide survey finds that providers are organizing into PPOs in response to competition — and in Ohio, Cleveland seems to be the forerunner for this newest system of alternate care.

Pierce MacKay, spokesman for St. Vincent Charity Hospital, Cleveland, which began the first PPO in the area, states that in order to be competitive, hospitals need a larger geographic area from which to draw a better mix of patients. In the hospital's vocabulary, "competitive" simply means achieving a level of annual income to afford the services it now provides and those it believes should be provided in the future. Not only are hospitals losing revenue to shrinking occupancy rates and reduced lengths of stay, but in Cleveland the problem is compounded by a decreasing population base. And, as the Cleveland HMOs continue to grow, the trend is most likely to continue.

The PPO, however, has been designed to meet this need for a larger geographic area head-on. Under St. Vincent's plan, for example, the consumer base is enlarged by contracting with businesses to provide health services for their employees.

But since employees live everywhere, the not-for-profit Ohio Health Choice Plan, Inc., was established, through which physicians and hospitals could contract to participate in a medical network in Cuyahoga as well as other surrounding counties. By the program's February 1 start date, over 30 sites were made available by the number of hospitals and physicians who had signed on as participating providers.

In order to be competitive, hospitals need a larger geographic area from which to draw a better mix of patients.

Under St. Vincent's plan (originally conceptualized by the AmeriTrust Company), there is no capitalization fee to be paid by the physician or by the hospital. Instead, time and expertise have been volunteered and a fee will be charged the employer for claims management. Both the hospital and the physician will discount their charge and fee respectively. The

average discount will be approximately 15%, but may range as high as 25%.

The Plan will preserve fee-for-service and patient choice of physician (an employee may choose his physician whether a member or a nonmember of the Plan) and will, of course, provide cost containment for the employer.

Across town at Marymount Hospital, a group of about 12 physicians has responded to the development of the St. Vincent Charity PPO — and its own interest in cost containment — by forming its own PPO, Northern Ohio Health Providers Organization, Inc. It, too, implemented its program February 1st, but with the Stouffer Corporation.

According to Dale Cowan, M.D., antitrust issues such as price fixing and closing a medical staff made it clear that an independent approach was necessary. Once the St. Vincent PPO was presented to the Marymount medical staff, Dr. Cowan presented his group's PPO to both the hospital and the physicians. Since the hospital has a 95% to 99% occupancy rate, it chose not to participate, but the hospital's physicians were invited to join the program if they wished.

The bylaws of this particular PPO provide for due process hearings on utilization violations. However, the contract expressly requires the

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Competition

What others are saying

At the end of 1982, the Ohio Hospital Association (OHA), in conjunction with the Ohio State Medical Association (OSMA) and the Ohio Osteopathic Association (OOA), took a look at "Health care in transition — the vital signs."

Competition and marketing were the topics of conversation at the Hyatt Regency, Columbus, during the seminar's first day. An assortment of speakers, ranging from bankers to economists, addressed the areas of investor-owned hospitals, HMOs, and future price competition. Following are highlights of their major points:

Health Care in Transition —

Bernard J. Lachner, President, Evanston Hospital, Evanston, Illinois.

- "The health care industry is a multibillion dollar industry with a commitment to life. We are major employers and high technology users, and hospitals do compete with each other. But maybe we should be more **price** competitive."
- "Quality and access of health care have been improved in recent years — but at high costs. Coupling the cost problem with the alleged scarcity of resources, it's possible that in the future, providers may have to become rationers of health care."
- "Hospitals have become the marketplace — yet we still feel that we have to apologize for any profits we make."
- "New and old questions will be raised in the near future, and we will have to find answers for such things as "Will old equal poor in the developing health care system? How will inflation and supply/demand be brought together? Who will represent the broad interest of the patient? Should physicians refer to a facility other than a hospital?"

General Economics. Are We Running Out of Money? — Ralph Andreano, Ph.D., Chairman, Department of Economics, University of Wisconsin, Madison, Wisconsin.

- "To put the picture of health care costs in perspective, other Western European countries also share a large percentage of their Gross National Product with health care. But in this country, health care

Public policy makers will continue to look for a magic bullet — something to blow away rising costs . . . but unless people's perception of health care changes, nothing can be done.

is expanding at twice the rate of the economy. The question that must be asked is: Will the public policy makers allow a sector to continue to grow at this rate? And the answer is no — simply because it precludes spending in other areas."

- "Public policy makers will continue to look for a magic bullet — something that will blow away rising health care costs. It may be regulation or competition — or they may drag that old war-horse, national health insurance, back into the picture. Everything will be tried, but everything will fail. Unless

people's perception of health care changes, then nothing much can be done."

- "People **want** to spend that much money on health care, so what's wrong with it? What's wrong with 15% of the GNP spent on health care? It could be 20%. The bottom line, however, is that public policy simply won't allow those rising costs to continue."

Federal Government

Reimbursement — David A. Winston, Senior Vice President, Blyth, Eastman, Payne, Webber, Health Care Funding, Washington, D.C.

- "The Reagan Administration didn't develop a national health policy because they felt that whatever they did would alarm someone. But they also knew that they couldn't balance the budget if Medicare continued to grow at the rate it has. So they formulated some short- and long-term strategies."
- "If you can't pay for what you promised, then it's time to look at the promise. Reducing health care benefits is not a serious possibility under the Reagan administration, so they will look to the providers. And they will look at copayments. They hope that development of the latter will discourage overutilization."
- "We have to break the idea that health care is free. The Administration will attempt to inject more market sensitivity into this area. . . maybe by mandatory copayments and deductibles."
- "The government learns something with every step it takes. If it is not able to put together a consensus on the private side, then someone is going to have to step in and impose controls. . . creating a system that is quasi-regulatory."

Karen S. Edwards

The Newest System of Alternate Care

continued

physician not to omit studies on behalf of the patient and not to jeopardize quality of care for cost containment. The physicians will be reimbursed fee-for-service based on the fee parameters contracted with Stouffer.

Along the freeway, on the same side of town Hillcrest Hospital also was forming its own nonprofit PPO. According to Dr. Paul Zeit, three self-insured corporations in Solon, Ohio, (Stouffer, AmeriTrust and Damag with a combined total of 7,000 employees) approached Hillcrest, asking it to participate in a PPO because its lower daily cost with high occupancy meant that quality care could be provided there employees at a lower cost.

Tentatively called the "Hillcrest PPO," it is a for-profit entity whose stock is wholly owned by a newly formed holding company which also owns the hospital. Membership is limited to physicians who hold staff privileges at Hillcrest and approximately 75% have stated interest in signing a participating agreement. Zeit does not believe there is a general oversupply of physicians that would cause a physician to join a PPO on his own. But he sees the PPO as a means to a greater patient base for physicians, enabling them to be competitive with other alternative delivery systems like the HMOs. Ever more important, however, is that in the hospital's fight for survival, PPOs can increase the hospitals' odds by providing a greater geographic range from which to draw patients. "Not all hospitals will survive in the next ten years, as more service is rendered outside of the acute-care center," Zeit explained. It could be the PPO, and its developing network of hospitals and physicians that provide the lifeline.

Initially, in Cleveland, the PPO network will consist of Hillcrest and Marymount Hospitals, but it is hoped a hospital on the west side of Cleveland also will join in.

There will be an 11-physician medical advisory committee which will elect its director and which will have a nonvoting seat on the board of directors of the PPO. The contract for physicians will expressly call for a

review of both quality of care and cost efficiency. The medical advisory committee will be the arbiter regarding quality and utilization for payment of claims.

Perhaps at this point we should discuss further the nature of this new alternative delivery system. In a recent article,* Sam Tibbetts, President of the Lutheran Society of Southern California, said that he believes a PPO can be described as halfway between an HMO and an indemnity type plan. Interstudy, on the other hand, says PPOs are an alternative delivery system having common characteristics which are variably expressed. They are:

Overall, the PPO has been a response to local needs and competitive opportunities in the marketplace.

- A provider panel — a limited number of physicians and hospitals
- A negotiated fee schedule and charge (frequently considered a discount)
- Utilization or claims review — some form of control mechanism
- Consumers not "locked in" — additional benefits created to encourage use of PPO providers
- Quick turnaround on provider claims

Overall, the PPO has been a response to local needs and competitive opportunities in the marketplace. Unlike the HMO, it provides an employee the choice of physician and there is no enrollment period. There usually is a financial reward of 100% coverage if a preferred provider is used, eliminating deductibles and copayments.

The hospital realizes better cash flow by quick turnaround on claims

payment. It enlarges its consumer base and can be more extensive with hospital privileges, which makes it more competitive with other hospitals. It can start with a minimum financial contribution other than the discount.

Physicians, too, can participate with few, if any, up-front dollars. They can preserve fee-for-service, but usually grant a discount. The patient base can be stabilized if competition from an oversupply of physicians or from other alternative delivery systems exists. Paperwork for claims is reduced and quick turnaround of reimbursement betters the physician's cash flow.

Businessmen like the feature of established accessibility for the employee to health care providers, but they are even more attracted by the negotiable fees and charges and by the provision of utilization control. They see both as an immediate attempt to contain costs and hope to work with the PPO to that end. This kind of working relationship is anticipated to provide wellness and counseling programs and may also allow the employer to influence the future design of the benefit package from use of data monitoring systems.

In spite of these stated pluses, some questions still need to be answered. For instance, how does a PPO select a physician? No one has provided a definition or criteria by which to judge the physician applicant as one who gives cost-effective, quality care. The hospital, too, must recognize that, although the participating physician is the principal supplier of more patients, these patients are employees of companies to which it must demonstrate cost efficiency. Discounts by physicians and hospitals are a beginning but the question arises, can quality medicine be provided while still bringing to the employer the long-term cost savings he seeks?

What might the future hold for PPOs? Surely, their structures and operations will be scrutinized for antitrust behavior. Nonetheless, because of the benefits perceived, there is currently a great amount of interest by hospitals, businesses and

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Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

AKRON

Frank B. Hall & Company of Ohio
425 West Market Street
Akron, Ohio 44303
(216) 535-2141

ASHTABULA

The Gluck Insurance Agency
2901 Market Street
Youngstown, Ohio 44507
Ohio toll-free: 800-362-6577

ATHENS

Earl E. Mathews, Inc.
8 North Court Street
Athens, Ohio 45701
(614) 593-5573

CANTON

Frank B. Hall & Company of Ohio
425 West Market Street
Akron, Ohio 44303
(216) 452-1366

CINCINNATI

Walter P. Dolle & Company, Inc.
424 Dixie Terminal Building
Cincinnati, Ohio 45202
(513) 421-6515

Rudd-Pomery Agency
105 West Fourth Street
Cincinnati, Ohio 45202
(513) 721-7766

S.P. Agency
1811 Losantiville Avenue
Cincinnati, Ohio 45237
(513) 531-8700

Wilder, Siegman & Associates
906 Main Street
Cincinnati, Ohio 45202
(513) 381-3100

Thomas E. Wood, Inc.
1500 Carew Tower
Cincinnati, Ohio 45202
(513) 852-6342

CLEVELAND

Dennis Insurance Agency
150 East Sprague Road
Broadview Heights, Ohio 44147
(216) 526-5700

John M. Haas Insurance
26130 Lorain Road
North Olmsted, Ohio 44070
(216) 779-8300
24545 Sprague Road
Columbia Station, Ohio 44028
(216) 235-8585

Juker Insurance Agency
4050 Erie Street
Willoughby, Ohio 44094
(216) 946-0245

R. Macknin Insurance Agency
3681 Green Road
Beachwood, Ohio 44122
(216) 464-4080

Stockdale Insurance Agency
24600 Center Ridge
Suite 133
Westlake, Ohio 44145
(216) 835-6950

Todd Whinnery Allen
4051 Erie Street
Willoughby, Ohio 44094
(216) 951-6100

United Agencies
1550 Hanna Building
Cleveland, Ohio 44115
(216) 696-8044

COLUMBUS

Neil Governor & Associates
1120 Morse Road
Columbus, Ohio 43229
(614) 846-0803

Gruber's Columbus Agency
3040 Riverside Drive
Suite 104
Columbus, Ohio 43221
(614) 486-0611

Insurance Office of Central Ohio
38 Jefferson Avenue
Columbus, Ohio 43215
(614) 221-5471

The Johnson Insurance Agency
3029 Sullivant Avenue
Columbus, Ohio 43204
(614) 276-1600

McCaffrey Insurance Agency
921 Chatham Lane
Columbus, Ohio 43221
(614) 451-3808

Sokol Insurance Agency
3242 East Main Street
Columbus, Ohio 43213
(614) 235-1111

Tice, Inc.
250 East Broad Street
Columbus, Ohio 43215
(614) 224-1291

DAYTON

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Dayton, Ohio 45401
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ELYRIA

Humphrey & Cavagna
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507 Broad Street
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(216) 322-5477
Lorain: (216) 244-3228

IRONTON

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P.O. Box 636
Ironton, Ohio 45638
(614) 532-8712
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Scioto Counties

KENT

W.W. Reed & Son
141 East Main Street
Kent, Ohio 44240
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LIMA

Stolly Insurance
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Springfield, Ohio 45501
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423 Washington Street
Steubenville, Ohio 43952
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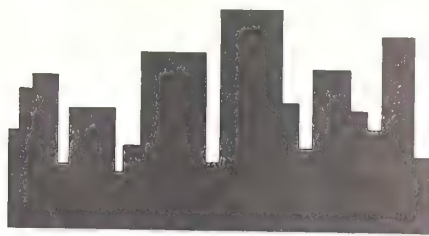
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Competition and Marketing
A physician's guide

The Guide to Ohio's Markets

Edited by Karen S. Edwards

Now that the broad picture of the Ohio health care market has been painted, it's time to step closer and examine the brush strokes. This article will examine five specific "markets" in Ohio. First, we'll take a look at the market itself — what kind of community is it, who are the patients seeking treatment? What types of practices are there? Are there new, alternative systems of care being practiced there? If so, what is their growth or impact in the area? Then we'll take a look at the providers in the area — at the growth of physicians and whether or not there is a noticeable want or influx of a particular specialty.

The five markets — all of them Ohio's larger metropolises — have been selected as representative of their area, hopefully indicative of the kind of competition and marketing one might expect in that specific section of the state. There is a broad range of marketing and competition going on in the state, and if you are unfamiliar with any area outside of your own, here is an opportunity to catch a glimpse of what your competition is doing elsewhere. And who knows? It may even provide you with a crystal ball look into your own future.



The Toledo skyline, courtesy of Toledo Chamber of Commerce

TOLEDO

Market description: The City of Toledo has a population of 351,000, but the metropolitan area is actually 796,000. Although it is the home of six Fortune 500 companies, Toledo relies heavily on the automobile industry, so the majority of patients seeking medical care here are blue collar laborers. Present unemployment in the area is 12.2%. The Academy of Medicine of Toledo and Lucas County notes that the majority of their referrals are welfare patients, or those on public assistance who need a primary care physician — especially a general or family practitioner.

Types of competition: Toledo has proven to be an area where the newer, alternate forms of health care do not seem as popular as the traditional forms. An HMO that was begun here two years ago has gone out of business, and while there was an attempt by a hospital chain to set up an IPA in Toledo, the project eventually was dropped. Now, there are several groups contemplating setting up a PPO, but it is still too early to see how they will fare with their idea.

However, Toledo does have five urgent care centers in the area, as well

as five family practice programs (although one of these is in the process of closing). Too, there are several hospitals that are involved in outpatient care.

Competition's impact on the market: While the competition, in the form of the urgent care centers, family practice programs and hospital outpatient care has made some impact on the traditional forms of practice — it really has not been very significant to date. Generally, the only changes noted are that patient visits seem to be down slightly and some physicians have gone to evening and Saturday hours.

The providers: There are approximately 1,000 physicians (including both M.D.s and D.O.s) in the Toledo area, a figure that remains fairly consistent through the years. No great influx has been noted in any specific area, but primary care physicians seem to head the list as the specialty most well represented. If there is one specialty where there seems to be a shortage, it would be in the area of ENT, where patients claim they have had to wait an unusually long time before getting in to see an ENT physician. — Lee F. Wealton, Executive Director, Academy of Medicine of Toledo and Lucas County.

DAYTON

Market description: Dayton's population is divided fairly evenly between blue collar (70,138) and white collar workers (77,106). Almost 60,000 members of Dayton's population fall into a managerial/administrative class with over 33,000 listing themselves as "professional specialists." Service workers number 34,402 and 1,612 members of city's population are listed as farmers/foresters.

Types of competition: While private practice continues to provide a large part of Dayton's medical care, family practice groups are being operated out of local hospitals. Ambulatory care centers, urgent care centers, clinics and health centers also operate in the area, as does an HMO and an IPA.

On the horizon, Humana, Inc., a successful investor-owned hospital system soon will be operating its new hospital in the Dayton area.

Competition's impact on the market: The traditional as well as the new alternate forms of health care seem to be coexisting successfully in the Dayton area — thus far. The new systems, however, are just that and perhaps it's too soon to make predictions about their eventual success in the area.

The only changes that traditional medicine has made — perhaps in direct competition to the new forms of care — is the development of satellite offices. Both hospitals and physicians are planning and opening these kinds of additional offices in Dayton.

The providers: There are presently 747 physicians in the Montgomery County Medical Society, a figure that has been increasing slowly but steadily over the last five years. According to recent figures, the greatest growth seems to be in the specialties of Emergency and Internal Medicine — and when queried, section presidents seem to concur. They list both internal and surgical specialties as having a "more than adequate" supply. — Constance Mahle, Administrative Assistant Montgomery County Medical Society.



The Columbus skyline, courtesy of Columbus Department of Development.

COLUMBUS

Market description: Columbus, Ohio's capital city, sits almost smack in the middle of Franklin County, an area that extends over 550 square miles of the state, and, according to the 1980 census, claims a population of 870,000. The city proper, as well as its contiguous suburbs, occupies almost all of Franklin County, and reaches into Licking, Delaware, Madison and Fairfield Counties for its 565,000 residents (again, according to the 1980 census).

Columbus serves as national headquarters for 50 major insurance companies, and is the home office site for Wendy's International and the American Electric Power Company. The city has a broad economic base, encompassing government, business, industry and manufacturing, education and transportation — creating a diverse population of white collar workers, laborers and academicians. Single and family member groups are drawn from a variety of ethnic backgrounds, though perhaps not as diverse as other areas in the state.

Type of competition: Columbus' traditional forms of medicine include: nine allopathic hospitals, one osteopathic hospital and state psychiatric facility (in Franklin County)

— in addition to 4,820 hospital beds (70 more are under construction). Alternately, there are some half dozen freestanding urgent care facilities or extended-hours family medicine centers, most of which have come into being in the past three years. In addition, there are at present, three operating HMOs. One is an IPA, sponsored by the Academy of Medicine of Columbus and Franklin County. Of the other two (both closed-panel types), one is operated by Blue Cross of Central Ohio, and the other is an osteopathic facility.

Competition's impact on the market: Columbus does not appear to have experienced the severe "competition crunch" that prevails in other parts of the country. In fact, there are areas within the county that are developing faster than the supply of primary care physicians can meet. Other areas of the city, notably the more economically depressed sections, have continued to have a shortage of private practice physicians — a condition which has been partially alleviated by neighborhood health centers, operated by the Columbus Health Department and other organizations.

Since the almost concurrent

development of the city's three HMOs, there have been no new efforts in this field for the past two years. Further, the advent of HMOs in Columbus does not, at this time, appear to have significantly affected the practice patterns of private physicians in Franklin County.

There is a distinction to be made between the true "urgent care" facility and the family practitioner who has simply extended office hours, and accepts all patients on a one-time basis. Both exist in the Columbus area, but not without controversy from some physicians.

The providers: Ohio State University's College of Medicine, located in Columbus, graduates some 225 physicians each year — many of whom remain in Columbus for residency training, and ultimately, private practice.

Currently, 1,500 M.D.s and 250 D.O.s are in practice in Franklin County — some of which have strictly an academic or hospital-based practice. The provider figure is one that seems to continue to grow at a slow, steady rate. No shortage or influx of specialties has been noted, however. — Sylvia Henderson, Associate Executive Director, The Academy of Medicine of Columbus and Franklin County.

CLEVELAND

Market description: Cleveland is a heavily industrial city with a large majority of blue collar workers. A number of ethnic groups also comprise the city's makeup. Unemployment, as elsewhere, is substantial and the number of patients on the various entitlement programs (Medicare, Medicaid, etc.) has expanded quickly in recent years.

Types of competition: Since a large part of health care expense has been shifted lately to private industry, it hardly seems surprising that a city as heavily industrialized as Cleveland, supports a diverse spread of health care competition.

Industry, in fact, has formed cost containment coalitions, established its own utilization review programs, and



In the treatment of insomnia

Good mornings start with restful nights.

Dalmane (*flurazepam HCl/Roche*)
patients fall asleep faster,
sleep longer and seldom awaken
with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.¹ In a double-blind crossover study of

42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam HCl/Roche) compared to placebo nights.² This difference was highly significant ($p < 0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.³

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.⁴ The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.⁵⁻⁸ Since the risk of oversedation, dizziness, confu-



sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.¹ Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.^{9,10} However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.¹¹ When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 3. Greenblatt DJ, Allen MD, Shader RL: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 4. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Meyer JA, Kurland KZ: *Milit Med* 138:471-474, Aug 1973. 6. Feller HL, Gibbons B: *Med Times* 101(8):130-135, Aug 1973. 7. Jacobson A et al: *Psychophysiology* 7:345, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 1978. 10. Kales A et al: *JAMA* 241:1692-1695, Apr 1979. 11. Monti JM: *Methods Find Exp Clin Pharmacol* 3(5):303-326, 1981.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

The Guide to Ohio's Markets

continued

has begun to direct its employees to less expensive (but more controlled) HMOs.

Cleveland does support a staff model HMO, a primary care network (Group Health Plan of Northeast Ohio), and a large assortment of urgent care, emergency and hospital satellite centers.

In addition, three PPOs are forming in Cleveland, in an effort to keep area hospitals surviving as quality health care institutions.

Competition's impact on the market: All of Cleveland's various forms of health care are still thriving, thanks in part to industry's encouragement and to the fact that a number of Cleveland residents do not appear to have private physicians. These patients use the satellite centers and the various competitive systems as an entry into health care, forcing several hospitals to open their own satellite centers to protect the market they already have.

"A tertiary care hospital, to survive, has to have a referral base," says Andre Marmen, public affairs director of Cleveland's St. Luke's Hospital, in the December 19, 1982 issue of the *Cleveland Plain Dealer*.

There are those, however, who think that the success of these systems are likely to droop. In the same article, Don Flagg, vice-president of the new Greater Cleveland Volunteer Health Planning Association, says that, in the

short range, these centers might save people a few dollars, but they are an additional capital expense and once they spring up on every corner, their volume falls off to where they are inefficient.

As in the other markets in the state, it seems that time will be the deciding factor for success or failure.

The providers: Membership in the Academy of Medicine of Cleveland has increased steadily over recent years, culminating in a current total of 3,500 physicians (and without any want or influx in a particular specialty noted).

Cleveland physicians, however, do seem sensitive to the competitive forces at work in their community. A physician advisory committee to Cleveland's "Ohio Health Choice Plan" recently wrote in a letter to other physicians, the following statement regarding competition:

"We, in the physician community, have several options. We can close our eyes to change and continue with the belief that such economic upheavals will not touch us, we can move vigorously to oppose change, or we can work innovatively to identify problems and develop alternatives that will allow both our own practices, and hospitals, to thrive and grow."

— George D. Reitz, Assistant Executive Director, Academy of Medicine of Cleveland and Cuyahoga County.



The Cleveland skyline, courtesy of Cleveland Convention and Visitor's Bureau.

Those brush strokes we've been examining in this article are about to change. Up until now, a very brief, general overview of competition in four of Ohio's marketplaces has been provided. But now, Leslie Laine, Communications Director for the Cincinnati Academy of Medicine, provides a different view — a reflective, sensitive, studied insight into the very nature of competition, based on the experiences in her own

community. The picture she paints is different — and yet probably common to the experiences of the other four markets.

The Journal provides this separate, more detailed look at our fifth market — Cincinnati — in hopes that you, the reader, will be able to more clearly understand the nature of competition, and why it has evolved into such an important issue on today's health care scene.

CINCINNATI

Competition: The Rising Tide

By Leslie Laine

Before 1980, the competition for medical care in Cincinnati consisted of a subtle undercurrent, tugging most noticeably on new physicians trying to establish themselves. Hospitals — looking ahead to new patient markets — began to feel its pull as well. But with the '80s came the pressure of a growing physician supply, the emergence of urgent care centers, and hospital expansion into outpatient care. The undercurrent has surfaced as a force to be reckoned with.

Some 2,000 physicians are concentrated in Hamilton County, the metropolitan hub of a three-state area. But the population is declining — down almost 10% between the national censuses of 1970 and 1980 — and is projected to continue to decline as residents relocate to the "boom town" areas of neighboring counties to the north and east.

That spells an even tighter patient market for the growing numbers of physicians. Academy of Medicine of Cincinnati membership rose 16% during that same period and 25% between 1970 and December 1982. That translates to a physician/patient

ratio of 229 physicians per 100,000 patients.

Many of the county's physicians are home grown — graduates of the University of Cincinnati (UC) College of Medicine. The presence of the college here plays a significant role in the local physician supply since, as recently as 1974, the college increased the size of its entering freshman class

With the '80s came the pressure of a growing physician supply, urgent care centers and hospital expansion . . . forces to be reckoned with . . .

by 72 students and now graduates a full complement of 192 each year. In addition, nearly 80% of the new doctors in the school's residency programs will remain here to hang their shingles.

No one's panicking over a physician glut here. Not yet. But a local hospital's recent national ad campaign to recruit physicians to its new office complex touched off a storm of protest. Doctors here aren't eager for more newcomers, a feeling that stems from a perception that our present physician supply is well-balanced with the demand.

"I can only speak here as an ophthalmologist," said Kenneth W. Rowe, M.D., in the spring, 1981 edition of *Cincinnati Medicine*, the quarterly publication of the Academy of Medicine of Cincinnati. "But if you look at the number of ophthalmologists in the area 20 years ago when I came here, we had a perceived and real shortage THEN that we don't have today. If we continue to train at the rate that we are, we will have more than we need."

Two physicians new to the area, surgeon Donna Stahl, M.D., and obstetrician Stephen Straubing, M.D., interviewed in the same issue, rejected the suggestion that their specialties were overcrowded. But they agreed the city had hit a "saturation level" for

An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceflor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated organisms:

Lower respiratory infections including pneumonia caused by *Streptococcus pneumoniae* (Diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organisms to Ceflor.

Contraindications Ceflor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings IN PENICILLIN-SENSITIVE PATIENTS: CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS INCLUDING ANAPHYLAXIS TO BOTH DRUG CLASSES.

Antibiotics including Ceflor should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins). Therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

In cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions General Precautions—If an allergic reaction to Ceflor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., antihistamines, anticholinergics, or corticosteroids.

Prolonged use of Ceflor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematology studies, or in transfusion cross-match procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

In patients with impaired renal function, the drug should be administered with caution. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceflor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Use in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceflor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceflor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours, respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceflor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceflor.⁷

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hour. The effect on nursing infants is not known. Caution should be exercised when Ceflor® (cefactor, Lilly) is administered to a nursing woman.

Use in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions—Adverse effects considered related to therapy with Ceflor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hyper-sensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hyper-sensitivity and have usually occurred during or following a second course of therapy with Ceflor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500); or abnormal urinalysis (less than 1 in 200).

[061782R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceflor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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both. And Dr. Straubing added, "I can see, however, where it might be a problem to set up an OB practice here in 1990. OB residencies have become more popular in the past few years and there is actually a surplus of applicants for the top rated OB programs in the country.

The question of the moment for Hamilton County is not, then, so much one of quantity as distribution. A 1980 federal report "Health Manpower Shortage Areas," listed 13 Cincinnati neighborhoods as lacking in adequate primary care service. The mostly undoctored neighboring counties of Adams, Brown, Clermont, Highland, and Warren also were listed, although an eastward movement of physicians in the past two years has begun to resolve distribution problems for parts of Clermont County.

Maldistribution within the city spells opportunity for young physicians who seek it out — such as Stephen Mueller, M.D., and David Williams, M.D. Their market research revealed that the western suburb of Delhi could easily



The Cincinnati skyline, courtesy of the Greater Cincinnati Convention and Visitor's Bureau.

Reaction to the centers, according to the fall, 1981 *Cincinnati Medicine*, has ranged from "cautious optimism to downright condemnation."

Proponents see them as a high quality, cost-effective alternative to hospital emergency room care. Critics worry that patients may confuse UCCs with true emergency facilities and lose valuable time in a health care crisis by going first to a UCC. And hospitals find themselves straddling a financial fence when faced with UCCs: the centers will likely establish referral patterns with nearby hospitals, but at the same time, will also cut into emergency room visits and other outpatient services. The Greater Cincinnati Hospital Council reported that 1981 emergency room visits were down, the first area-wide decline in at least 15 years.

Private physicians, who also have cause for concern, are responding by beginning to keep offices open longer each week, offering night and weekend hours. And an enterprising group of physicians in the beleaguered east side — faced with the prospect of five UCCs in the neighborhood, has formed a coalition of virtually every specialty in the area. They hope to maintain their visibility as private physicians amid the high-powered promotion of the UCCs. Organized late in 1982, the coalition has yet to launch its attack, but intends to

promote the availability of the group's members and to install an answering/referral service to increase their accessibility.

The UCCs represent the first major innovation in the delivery of local health care since the establishment of Health Maintenance Plan (a closed-panel health maintenance organization) and the Academy of Medicine-sponsored independent physicians association ChoiceCare in the 1970s. But other competitive forces are developing now and it's too early to tell what impact they will have.

As reported in the fall, 1982 *Cincinnati Medicine*, several multihospital systems have organized locally. "The Midwest Health System, the new nonprofit holding corporation established by Jewish Hospital and Otto C. Epp Memorial Hospital, already has dreams of expansion according to Jewish Hospital President Warren Falberg." Physician and hospital management services are on the list of Midwest's marketing goals.

The Mercy Health Care System, operated by the Sisters of Mercy of Cincinnati, is focusing on the expanding markets in Eastern Cincinnati, where organization plans to locate an urgent care center. Bethesda Oak and North Hospitals also are branching out with ambulatory care centers in Sharonville and Lebanon, Ohio. A third is slated

continued on next page

Reaction to urgent care centers has ranged from "cautious optimism" to "downright condemnation."

accommodate the internal medicine practice they intended to set up.

Yet with all arrangements made, and just weeks away from moving into their new office, they discovered a competitor they hadn't counted on was moving in next door.

Their new neighbor was MedFirst, an urgent care center (UCC) operated by Humana, Inc. Four such franchised centers opened in Hamilton County in 1982, joining three other individually owned UCCs, the first of which opened some three years ago. At least another three are planned, including one to be built by an Eastern Cincinnati hospital.

for the popular east side.

And what of PPOs, the newest catchword of the industry? According to the fall, 1982 *Cincinnati Medicine*, "Although no formal programs have yet been announced, all the area hospitals are expecting to be approached very shortly by business and industry about establishing preferred provider organizations."

The UC Medical Center also must be considered in any scenario of local competition. With the establishment of the University of Cincinnati Hospital this past fall, the objective, said Medical Center Director Robert Daniels, M.D., is to "create a university hospital that has regional in addition to local responsibility, a hospital that places increasing

emphasis on tertiary care, while maintaining active emergency and primary care services." Dr. Daniels acknowledges that the University Hospital's unique position offers it unique competitive advantages. "Many of the clinical innovations and new, highly specialized technical interventions will occur here first, and the University Hospital and Medical Center will become the vehicle for introducing them to this region. It also may be the only place where some services are available," Dr. Daniels concluded.

The tide of competition is indeed rising in Southwest Ohio and only time will tell how private physicians will survive its highest reaches.

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Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Thiamine HCL (B-1)		25 mg.
Riboflavin (B-2)		2 mg.
Pyridoxine HCL (B-6)		10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN[®]/100 mg.

Each blue tablet contains:

Nicotinic Acid		100 mg.
Niacinamide		75 mg.
Ascorbic Acid		150 mg.
Thiamine HCL (B-1)		25 mg.
Riboflavin (B-2)		2 mg.
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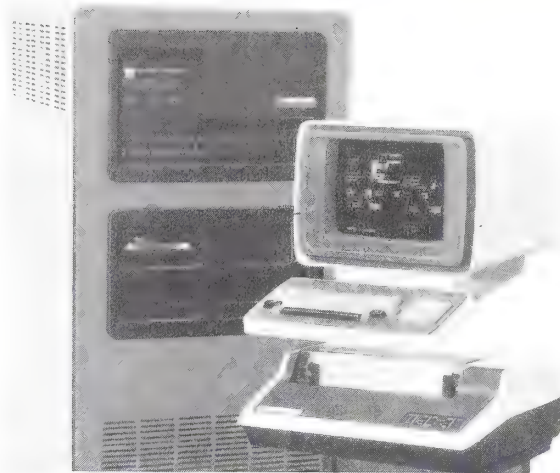
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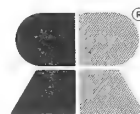
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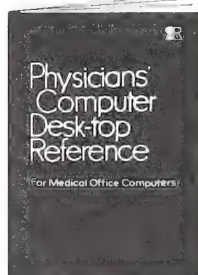
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1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System** light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory** bronchospasm. **Hematologic** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous** reversible alopecia. **Oculomucocutaneous** reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

TABLETS

— Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

— Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

— Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

— Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTION

— Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).

7997/882

Reference: 1 Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981



AYERST LABORATORIES
New York, N.Y. 10017

Ohio Maternal Mortality Study

Primary Causes of Death

Editor's Note: Due to space limitations, the Journal was unable to carry the entire list of the Primary Causes of Death, listed in the Ohio Maternal Mortality Study, which appeared in the December 1982 Journal. Numerous requests for the additional causes have prompted the publication of this complete list.

CLASSIFICATION OF PRIMARY CAUSES OF DEATH:

HEMORRHAGE	7	Hypertension, chronic (incl. hypertension with cerebrovascular hem.)	1
Abortion, without sepsis	1	Eclampsia	5
Afibrinogenemia	0	Preeclampsia	0
Abruptio	0	Renal disease	0
Am. fl. embolus	0	OTHER	20
Dead fetus	0	Amniotic fl. em. (no hem.)	3
Ruptured uterus	0	Anesthesia	1
Atony, uterine, postpartum	2	(general)	0
Ectopic pregnancy without sepsis	3	(regional)	1
Laceration, extrauterine	0	Brain, edema, unspecified	1
Placenta praevia	1	Cardiac disease	0
Retained placenta	0	Cerebrovascular embolism (no tox.)	0
Ruptured uterus (no afibrin.)	0	Chorioepithelioma	3
Other	0	C.V.A.	0
INFECTION	5	Hydatid mole	0
Abortion, alleged "criminal"	0	Liver disease	0
Abortion, septic spontaneous	0	Pulmonary edema	2
Up. resp. inf.	0	Pulmonary embolus	5
Peritonitis	0	Renal disease, chronic, unspecified	1
Septicemia (puerperal sepsis)	3	Suicide	2
Septicemia (other)	2	Trauma, massive, external	0
Other	0	All other	2
TOXEMIA	6	"High Risk" OB patients	13
Acute yellow atrophy	0	"High Risk" condition related to cause of death ..	10

Candidates for nutritional therapy...

10,000,000

alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.¹

25,500,000 geriatric

patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.²

23,500,000 surgical

patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.³



Before prescribing, please consult complete product information, a summary of which follows:

Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B₁ (as thiamine mononitrate), 20 mg vitamin B₂ (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B₆ (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B₁₂ (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

Contraindications: Hypersensitivity to any component.

Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inade-

quately treated with B₁₂.

Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

Adverse Reactions: Adverse reactions have been reported with specific vitamins and

5,000,000 hospital patients with infections.⁴

Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.³

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.⁵



minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Berocca Plus

A balanced formula for prophylactic or therapeutic nutritional supplementation.

Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus,

highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

candidates for

Rx ONLY **Berocca[®] Plus** TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

Ohio State Medical Association 1982 Budget Allocation

	01 Admin.	02 Educ. & CME	03 Health Ed.	04 Field Serv.	05 Fiscal Mbrshp.
Furniture & Equipment	\$ 2,000.00	\$ 700.00	\$ 100.00	0	\$ 18,700.00
Term Debt: Current	2,175.00	2,625.00	1,075.00	1,075.00	3,675.00
Journal: Publication Cost	0	0	0	0	0
Salaries & Ins. Benefits	199,715.81	136,096.75	65,672.24	67,292.92	212,663.85
Staff Development	50,000.00	0	0	0	0
Staff Expense	14,000.00	5,000.00	4,000.00	7,800.00	12,000.00
President Expense	12,000.00	0	0	0	0
President-Elect Expense	6,000.00	0	0	0	0
Officer Honorariums	19,000.00	0	0	0	0
Council Expense	55,000.00	0	0	0	0
AMA Del/Alt Expense	0	0	0	0	0
Student Business Section	20,000.00	0	0	0	0
Ad Hoc: Long Range Plan	0	0	0	0	0
Committee: Ad Hoc Delegate	0	0	0	0	0
Committee: AMA-ERF	0	0	0	0	0
Committee: Art & Culture	0	0	0	0	0
Committee: Audit & Approp.	0	0	0	0	27,000.00
Committee: Cancer	0	0	750.00	0	0
Committee: Editorial Board	0	0	0	0	0
Committee: Education	0	7,600.00	0	0	0
Committee: Emrgcy. & Disas.	0	3,100.00	0	0	0
Committee: Cost Effective	0	0	0	0	0
Committee: Envirn. Liaison	0	0	500.00	0	0
Committee: Govt. Med. Care	0	0	0	0	0
Committee: Hlth. Manpower	0	0	1,500.00	0	0
Committee: Hlth. Planning	0	0	0	0	0
Committee: Hosp. Relations	0	0	0	0	0
Committee: Hlth. Pln. Ad. Pnl.	0	0	0	0	0
Committee: Jails & Prison	0	0	0	0	0
Committee: Judicial/Prof.	0	0	0	0	0
Committee: Matrn./Neonatl.	0	0	0	0	0
Committee: Med. Serv. Review	0	0	0	0	0
Committee: Members Ins.	0	0	0	0	0
Committee: Membership	0	0	0	0	0
Committee: Mental Health	0	0	5,000.00	0	0
Committee: Non-Dues Income	0	0	0	0	0
Committee: Prof. Liab. Task	0	0	0	0	0
Committee: Communications	0	0	0	0	0
Committee: School Health	0	0	5,500.00	0	0
Committee: Stdy. & Rev. Act	0	0	0	0	0
Committee: On Program	0	4,600.00	0	0	0
Committee: Special Educ.	0	0	500.00	0	0
Committee: State Legis.	0	0	0	0	0
Task Force: Hlth. Care Mkt.	0	0	0	10,200.00	0
Annual Meeting	0	120,221.00	0	0	0
Bad Debt Expense	0	0	0	0	0
Building Expense	6,264.00	7,560.00	3,096.00	3,096.00	10,584.00
Car Lease	20,187.00	0	3,377.00	4,400.00	3,100.00
Contributions	0	0	0	0	0
Councilor Dist. Conference	6,000.00	0	0	0	0
Data Processing	0	0	0	5,000.00	44,546.00
Depreciation Expense	7,482.00	9,030.00	3,698.00	3,698.00	12,642.00
Equipment Lease & Supply	5,580.60	5,580.60	1,831.80	1,831.80	8,349.60
Equipment Maint. Agreement	589.50	589.50	193.50	193.50	882.00
Emergency Fund	1,120.00	1,110.00	1,110.00	1,110.00	1,110.00
Insurance and Bonding	17,941.00	1,406.00	1,406.00	1,406.00	1,443.00
Interest Expense	991.80	1,197.00	490.20	490.20	1,675.80
Legal Expense	75,000.00	0	0	0	0
Library	606.00	605.00	606.00	1,000.00	605.00
Meeting Expense	12,000.00	0	0	5,200.00	0
Misc. Supplies	1,310.00	1,310.00	430.00	430.00	1,960.00
OSMAgram	0	0	0	0	0
Pension Expense	10,600.00	7,100.00	3,600.00	3,600.00	11,300.00
Postage	6,445.20	6,445.20	2,115.60	2,115.60	9,643.20
Printing & Office Supply	4,047.90	4,047.90	1,328.70	1,328.70	6,056.40
Prof. Relations Activity	886.92	879.01	879.01	879.01	879.01
Public Relations Expense	0	0	0	0	0
Taxes: Payroll	9,550.00	9,370.00	3,695.00	4,420.00	13,735.00
Taxes: State and Local	0	0	0	0	0
Telephone and Telegraph	7,205.00	7,205.00	2,365.00	2,365.00	10,780.00
TOTAL 1983 BUDGET	\$573,697.73	\$343,377.96	\$114,819.05	\$128,931.73	\$413,329.86

06 Govt. Rel.	07 Commun.	08 Org. Serv.	09 State-Fedl. Leg.	11 Rental Area	YTD Actual Thru 11/82	1982 Budget Totals	1983 Budget Totals
0	\$ 2,000.00	\$ 1,967.00	0	0	\$ 17,445.56	\$ 91,450.00	\$ 25,467.00
2,025.00	2,625.00	2,825.00	4,050.00	2,850.00	24,078.07	24,857.91	25,000.00
0	195,000.00	0	0	0	169,264.52	186,000.00	195,000.00
133,835.72	165,443.63	134,641.94	216,916.03	0	810,395.59	1,194,840.67	1,332,278.89
0	0	0	0	0	0	40,000.00	50,000.00
14,000.00	10,000.00	7,000.00	50,000.00	0	72,630.44	125,300.00	123,800.00
0	0	0	0	0	3,330.37	12,000.00	12,000.00
0	0	0	0	0	606.84	6,000.00	6,000.00
0	0	0	0	0	15,000.00	19,000.00	19,000.00
0	0	0	0	0	29,022.37	63,000.00	55,000.00
0	0	77,080.00	0	0	38,713.37	71,075.00	77,080.00
0	0	0	0	0	4,525.47	9,100.00	20,000.00
0	0	0	5,000.00	0	1,146.85	7,500.00	5,000.00
0	0	275.00	0	0	0	0	275.00
0	0	0	0	0	0	0	0
0	600.00	0	0	0	0	600.00	600.00
0	0	0	0	0	34,106.04	21,000.00	27,000.00
0	0	0	0	0	0	750.00	750.00
0	1,000.00	0	0	0	0	0	1,000.00
0	0	0	0	0	4,386.02	7,600.00	7,600.00
0	0	0	0	0	1,463.24	3,400.00	3,100.00
1,600.00	0	0	0	0	358.60	1,600.00	1,600.00
0	0	0	0	0	160.72	250.00	500.00
1,800.00	0	0	0	0	182.55	2,200.00	1,800.00
0	0	0	0	0	808.90	2,000.00	1,500.00
1,700.00	0	0	0	0	0	1,900.00	1,700.00
0	0	0	0	0	0	0	0
2,000.00	0	0	0	0	0	0	2,000.00
0	0	0	250.00	0	0	250.00	250.00
0	0	0	8,600.00	0	183.80	600.00	8,600.00
2,200.00	0	0	0	0	595.66	1,800.00	2,200.00
0	0	0	0	0	0	0	0
0	0	2,430.00	0	0	0	300.00	2,430.00
2,200.00	0	0	0	0	919.47	3,000.00	2,200.00
0	0	0	0	0	1,555.13	4,500.00	5,000.00
0	0	0	0	0	0	0	0
0	0	0	0	0	80.63	500.00	0
0	800.00	0	0	0	397.58	800.00	800.00
0	0	0	0	0	3,620.48	6,250.00	5,500.00
600.00	0	0	0	0	0	0	600.00
0	0	0	0	0	205.96	6,450.00	4,600.00
0	0	0	0	0	0	500.00	500.00
0	0	0	3,000.00	0	943.33	3,000.00	3,000.00
0	0	0	0	0	876.70	10,000.00	10,200.00
0	0	0	0	0	113,680.69	124,192.00	120,221.00
0	500.00	0	0	0	0	500.00	500.00
5,832.00	7,560.00	8,136.00	11,664.00	8,208.00	42,470.25	48,430.80	72,000.00
6,620.00	3,200.00	3,200.00	6,400.00	0	35,404.91	40,570.00	50,484.00
0	0	0	0	0	0	0	0
0	0	0	0	0	4,287.69	10,000.00	6,000.00
0	5,000.00	0	3,000.00	0	18,581.66	46,000.00	57,546.00
6,966.00	9,030.00	9,718.00	13,932.00	9,804.00	0	57,420.00	86,000.00
2,769.00	6,475.20	4,643.40	5,538.00	0	26,522.63	39,600.00	42,600.00
292.50	684.00	490.50	585.00	0	3,713.99	5,000.00	4,500.00
1,110.00	1,110.00	1,110.00	1,110.00	0	17,178.76	13,200.00	10,000.00
1,406.00	1,443.00	1,406.00	1,443.00	0	15,084.02	33,600.00	29,300.00
923.40	1,197.00	1,288.20	1,846.80	1,299.60	7,933.74	11,739.70	11,400.00
0	0	0	0	0	37,581.49	75,840.00	75,000.00
700.00	606.00	605.00	1,350.00	0	4,509.80	4,700.00	6,683.00
500.00	1,500.00	0	0	0	2,806.15	21,000.00	19,200.00
650.00	1,520.00	1,090.00	1,300.00	0	5,388.96	10,000.00	10,000.00
0	45,000.00	0	0	0	28,804.90	40,000.00	45,000.00
7,100.00	9,200.00	7,100.00	11,300.00	0	147.90	58,200.00	70,900.00
3,198.00	7,478.40	5,362.80	6,396.00	0	40,495.43	49,750.00	49,200.00
2,008.50	4,696.80	7,568.10	13,117.00	0	21,102.17	40,000.00	44,200.00
879.01	879.01	879.01	879.01	0	9,169.00	10,165.00	7,919.00
0	65,000.00	0	0	0	32,354.32	60,000.00	65,000.00
9,290.00	11,040.00	7,800.00	13,215.00	0	57,604.14	73,770.92	82,115.00
0	0	0	0	0	215.71	0	0
3,575.00	8,360.00	5,995.00	7,150.00	0	36,931.30	49,800.00	55,000.00
<u>\$215,780.13</u>	<u>\$568,948.04</u>	<u>\$292,610.95</u>	<u>\$388,041.84</u>	<u>\$ 22,161.60</u>	<u>\$1,750,817.73</u>	<u>\$2,853,302.00</u>	<u>\$3,061,698.89</u>

Over 100,000,000 RXS in 20 years

Specify only
Hygroton® (chlorthalidone USP)
for
predictability
and
dependability



TELEPHONE _____
DEA _____
PATIENT NAME _____
ADDRESS _____ AGE _____
DATE _____

Rx

*Hygroton 25mg
Tabl. #100
sig. 1 tablet daily
Dispense as written*

B. M. K.

- Proven efficacy and safety
- Convenient once-daily dosage
- Supported by extensive research and quality control

BRIEF SUMMARY

Indications: Hypertension, adjunctive therapy in edema.

Contraindications: Anuria, hypersensitivity to chlorthalidone or other sulfonamide-derived drugs.

Warnings: Should be used with caution in severe renal disease, impaired hepatic function or progressive liver disease. May add to or potentiate the action of other antihypertensive drugs. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. There is a possibility of exacerbation or activation of systemic lupus erythematosus with thiazides, which are related to chlorthalidone. This has not been reported with chlorthalidone. Thiazides cross the placental barrier and appear in cord blood. Use in pregnant women requires that the anticipated benefits of the drug be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. In nursing mothers, thiazides cross the placental barrier and appear in breast milk. If use of the drug is essential, the patient should stop nursing.

Precautions: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving chlorthalidone should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia

Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic

therapy. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance.

Adverse Reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis; dizziness, vertigo, paresthesias, headache, xanthopsia; leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia; purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis) (cutaneous vasculitis), Lyell's syndrome (toxic epidermal necrolysis). Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. Other adverse reactions include hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, impotence. Whenever adverse reactions are moderate or severe, chlorthalidone dosage should be reduced or therapy withdrawn.

Usual Dose: One tablet daily.

How Supplied: Tablets—100 mg. (white, scored), 50 mg. (aqua) in bottles of 100, 1000 and 5000; 25 mg. (peach) in bottles of 100 and 1000; unit-dose blister packs, boxes of 100 (10 x 10 strips).

USV
LABORATORIES

USV Laboratories Inc.
Manati, P.R. 00701

The 1983

OSMA ART and CULTURE COMMITTEE'S

Photographic Exhibit



"Comrades" by Marvin Aronoff, M.D., Cincinnati

The Ohio State Medical Association's Art and Culture Committee will sponsor a photographic exhibit and competition. The 1983 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1983 Annual Meeting, Columbus, where the entries will be displayed. Winners will not necessarily appear on future Journal covers.

Photographs may be entered in two divisions: Black and White, and Color.

Entries must be in print form (8" x 10" or 11" x 14") in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a \$10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

Name _____
 If Nonmember, Spouse's Name _____
 Street _____
 City _____ State _____
 County _____ Zip _____
 Telephone _____

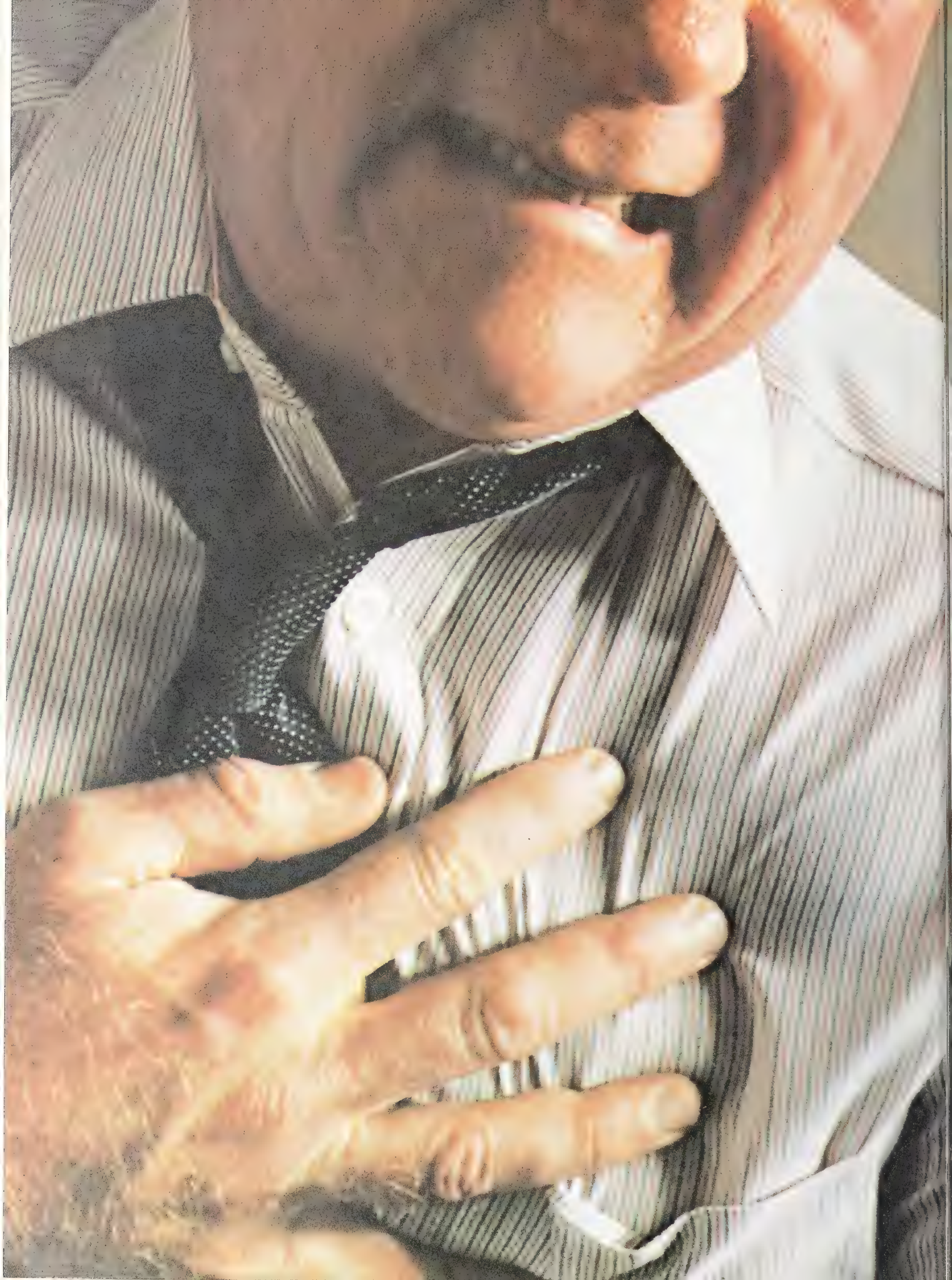
Information about photograph:
 (provide as much as possible)

Camera _____	Lens _____
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ANGINA

INDERAL[®] TODAY CAN TAKE (PROPRANOLOL HCl) THE CONCERN OUT OF TOMORROW.

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(PROPRANOLOL HCl)

THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD.



The appearance of these tablets is a trademark of Ayerst Laboratories

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
Inderal[®] (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when Inderal is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory** bronchospasm. **Hematologic** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase lactate dehydrogenase.

HOW SUPPLIED

TABLETS

Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTION

Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).



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New fitness publication

• "Corporate Fitness and Recreation," a bimonthly publication aimed at corporate fitness directors, medical directors and employee service directors, premiered this fall, and is expected to meet the needs of an expanding market in this area. The publication's managing editor said that while only 3% of U.S. companies offer some form of employee recreation or fitness programs at present, that figure should exceed 25% by 1990. For further information on the publication, contact Steve Goldstein, director of sales at Brentwood Publishing Corporation, 213-826-8388.

"The rehabilitation of head-injured patients is an intensive, sophisticated procedure"

says Jose Amayo, M.D., Harmarville Rehabilitation Center

"From morning 'til night, head-injured patients are involved in rehabilitation," says Dr. Amayo, director of Harmarville's head injury program.

"Our program has four primary elements: cognitive retraining to improve memory, attention span and communication skills; physical restoration services to help patients relearn walking and caring for themselves; a vocational program to prepare patients for employment, further training or education; and programs to help patients deal with routine social and recreational activities.

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Other special Harmarville programs:

- Pain program to help patients control and live with pain, particularly neck- and back-injured persons.
- Neuro-spinal program for the rehabilitation of quadriplegics and paraplegics.
- Claims Assessment for Rehabilitation Evaluation and Services (CARES) for returning injured workers to maximum level of function and employment.

For more information on Harmarville, its head injury program and admission procedures, call Dr. Amayo, 781-5700.



Harmarville Rehabilitation Center, P.O. Box 11460, Guys Run Road, Pittsburgh, PA 15238

RUDOLF COOKS, M.D., St.

Petersburg, Florida; University of New York College of Medicine, Syracuse, 1931; age 78; died November 5, 1982; member OSMa and AMA.

THOMAS DICKSON, M.D.,

Cincinnati, Ohio; Medical College of Ohio, Cincinnati, 1907; age 97; died November 1, 1982; member OSMa and AMA.

RUDOLPH DIETHELM, M.D.,

Toledo, Ohio; St. Louis University School of Medicine, 1921; age 85; died November, 1982; member OSMa and AMA.

JOHN FLEMING, M.D., Cincinnati, Ohio; Harvard Medical School, Boston, 1934; age 76; died November 23, 1982; member OSMa and AMA.

ARTHUR P.R. JAMES, M.D.,

Seattle, Washington; University Toronto Faculty of Medicine, Ontario, 1926; age 79; died December 7, 1982; member OSMa and AMA.

WILLIAM McINTOSH, M.D.,

Cuyahoga Falls, Ohio; Johns Hopkins University School of Medicine, Baltimore, 1919; age 92; died May 1, 1982; member OSMa and AMA.

JOHN EASTON LELAND, M.D.,

Cincinnati, Ohio; Howard University College of Medicine, Washington, 1935; age 77; died November 8, 1982; member OSMa and AMA.

ROBERT M. LEMMON, M.D.,

Akron, Ohio; Ohio State University College of Medicine, 1924; age 86; died November 1, 1982; member OSMa and AMA.

PAUL F. ORR, M.D., Perrysburg,

Ohio; Harvard Medical School, Boston, 1925; age 84; died November 14, 1982; member OSMa and AMA.

JOSEPH SCHAUER, M.D.,

Fairborn, Ohio; University of Cincinnati College of Medicine, 1941; age 68; died December 2, 1982; member OSMa and AMA.

ALBERT SELFMAN, M.D., N.

Miami Beach, Florida; Vanderbilt University School of Medicine, Nashville, 1938; age 76; died August, 1981; member OSMa and AMA.

CLELAND THOMAS, M.D.,

Norwalk, Ohio; Ohio State University College of Medicine, 1930; age 77; died November 11, 1982; member OSMa and AMA.

BRIEF SUMMARY PROCARDIA - CAPSULES

For Oral Use

(nifedipine)

INDICATIONS AND USAGE: 1. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

2. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antihypertensive medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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*"I can do things that I
couldn't do for 3 yrs. including
joining the human race again."*

*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for
your patients—having fewer anginal attacks, taking fewer
nitroglycerin tablets, doing more, and being more productive
once again.

Side effects are usually mild (most frequently reported are
dizziness or lightheadedness, peripheral edema, nausea,
weakness, headache and flushing, each occurring in about 1%
of patients, transient hypotension in about 5%, palpitation in
about 2% and syncope in about 0.5%).

*Quotes from an unsolicited
letter received from an
angina patient. While this patient's experience
is representative of many
unsolicited comments received,
not all patients will respond to
Procordia nor will they all
respond to the same degree.*

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for the varied faces of angina

* Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA
(NIFEDIPINE) Capsules 10 mg

Please see PROCARDIA brief summary on adjoining page.

Emergency Medicine

By Gina DiBlasio Cummins

Fifteen years ago the unconscious bleeding victims of a bus accident would have been rushed to the nearest hospital before treatment could be administered. Today, a paramedic team, arriving within minutes of an accident, begins lifesaving treatment immediately.

This efficient use of time has been the greatest improvement in the practice of emergency care — and often has made the difference between life and death.

"This increased efficiency and upgrading in the quality of urgent care treatment has been a continuous effort over the past 15 years, and was the main goal of the physicians who worked to create this relatively new specialty of emergency medicine," says Andrew DiBartolomeo, M.D., an Akron emergency medicine physician and chairman of both the Government Affairs Committee for the National College and of the Governor's Advisory Council in EMS affairs for the State of Ohio.

He notes that emergency medicine has changed and improved dramatically in several respects. "First, we have become much more successful in treating life-and-limb-threatening illnesses and injuries. Second, with the tremendous improvement in prehospital care, many more emergent patients are

continued on next page



Dr. DiBartolomeo discusses the Defibrillator — a lifesaving machine that produces an electrical charge to the heart to help save heart attack patients.

continued

coming into the emergency department alive — and with a good chance of full recovery.”

He attributes this significant upgrading in prehospital care to emergency medicine physicians and emergency medical technicians (EMTs) who have streamlined the old system.

“The EMTs have become the arms and minds of physicians outside the hospital . . .”

“The EMTs have become the arms, legs and eyes of physicians outside the hospital and together we form a network of excellent emergent care. In the past, the victim would be rushed to the emergency department before

continued on page 150



Andrew DiBartolomeo, M.D., an Akron emergency medicine physician, relays a message over the telemetry, a two-way radio communication system. This specialized machine makes communication possible between a physician in the emergency room and emergency medicine technicians at the scene of an accident.

When
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is due to androgenic deficiency.
Confidence comes with
NEW ANDROID®/F
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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypersensitivity particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. W. Warrington, M.D., J. S. Saperstein, M.D., *Hormones for Improved Sexuality in the Male and the Female Climacteric, Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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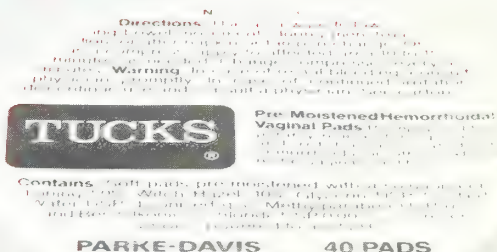
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Once pain and inflammation subside, for dual action recommend regular ANUSOL[®] and TUCKS[®].



Please see opposite page for brief summary of prescribing information.

*Meeting of Am Soc Colon/Rectal Surgeons, May 1980

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Vaginal Uses — Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC* SUPPOSITORIES

Hemorrhoidal Suppositories with Hydrocortisone Acetate

ANUSOL-HC* CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg, bismuth subgallate, 2.25% bismuth resorcin compound, 1.75% benzyl benzoate, 1.2%, Peruvian balsam, 1.8%, zinc oxide, 11.0 mg, also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg, also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol* Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: **General:** Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy: See "WARNINGS."

Pediatric Use: Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove the tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream — one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 15° - 30° C (59° - 86° F).
1089G010

Emergency Medicine

continued

treatment of any sort was administered. Now, EMTs can begin urgent care treatment when indicated en route to the hospital and consequently save more lives."

Dr. DiBartolomeo says that EMTs are specially trained to administer a wide variety of life-saving procedures, including stabilizing a trauma or cardiac patient without invasive surgery; starting IVs and medication; placing appropriate splints on a patient and placing MAST (military antishock trousers) on a patient within seconds to prevent or treat shock from bleeding.

In addition to improved prehospital care, emergency department equipment has grown more sophisticated. For example, a two-way

electrocardiogram reading that comes directly from the patient at the scene to the TV screen or readout in the emergency department. This communication system not only allows the physician and paramedic to discuss the best type of treatment to administer, but also allows the physician to guide a paramedic through more difficult life-saving procedures at the scene and en route.

"Once a patient arrives at the hospital, he can expect to receive the best care possible since several emergency medicine specialists and emergency department staff are always present. Since we never know when an emergency will arise, we must be prepared to offer quality care around the clock."

Of course, the advantages of

The telemetry, a specialized radio-TV, allows a physician in the emergency room to communicate with the paramedics at the scene of the emergency.

communication system called a telemetry now is available. This specialized radio-TV allows a physician in the emergency department to communicate with the paramedics at the scene of the emergency. The physician in the emergency department can talk directly to the EMT and assess the situation from the EMT's description as well as from the

emergency department care are costly. "In fact, the price of emergency department care is too costly — but that's because of the overwhelming overhead of the hospital." He explains that on the average 25% of an emergency department bill represents physician services and that 75% of the bill represents hospital costs." Dr. DiBartolomeo notes that the

continued on page 153



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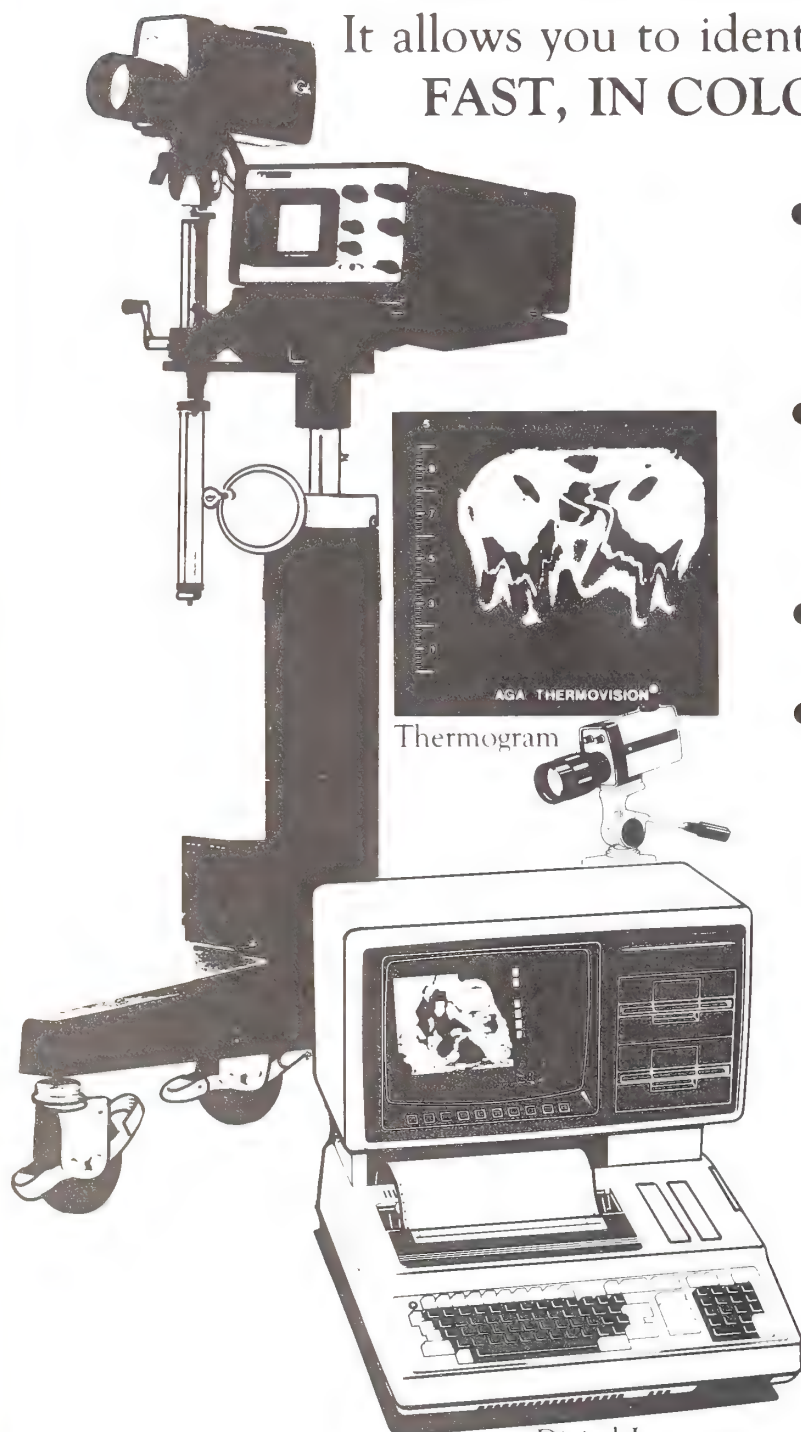
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Emergency Medicine

continued

tremendous cost of overhead is reflected in a patient's bill whether he comes to the emergency room with an appendicitis attack — or a head cold. "However, if the patient feels he has an emergency, then, as far as we're concerned, it's an emergency until proven otherwise." Of the number of people who come to the emergency room claiming chest pain, for example, less than 50% have heart attacks. "However, we can't diagnose this until the patient has been channeled through our costly emergency department system of evaluations."

In addition to the problems of high cost, Dr. DiBartolomeo says that emergency medicine also faces problems with physician acceptance — especially with family practitioners. "Some physicians erroneously think that emergency medicine physicians are trying to take patients away from them," Dr. DiBartolomeo says, but he emphasizes that emergency medicine

is not in the business of developing a private practice. "Although I will usually treat anyone who comes through these doors seeking help, I will later refer the patient back to his own physician, or try to find a private practitioner for him. I really believe in

As the elderly population increases, and family practices become larger, the emergency room will become even busier.

family physicians — but I can't turn people away if potential emergency conditions are apparent. For whatever reason they come, it's our responsibility to provide that individual with care."

In addition, patients frequently will come to the emergency room because

they are unwilling to wait for an appointment with their physician. "They will come to the emergency room where they know that they can get immediate attention." Dr. DiBartolomeo predicts that as the elderly population increases and family practices become larger, the emergency department will become even busier. However, he feels that the emergency department — at present and in the future — will be able to absorb this influx of patients as emergency medicine continues to grow in the community. "As we continue to improve emergency patient care as well as the working relationships between the emergency department staff and other physicians, we will be able to provide patients with a second chance to life that they wouldn't have received 15 years ago."

Gina DiBlasio Cummins is Editor of Synergy, and a staff writer for the Journal

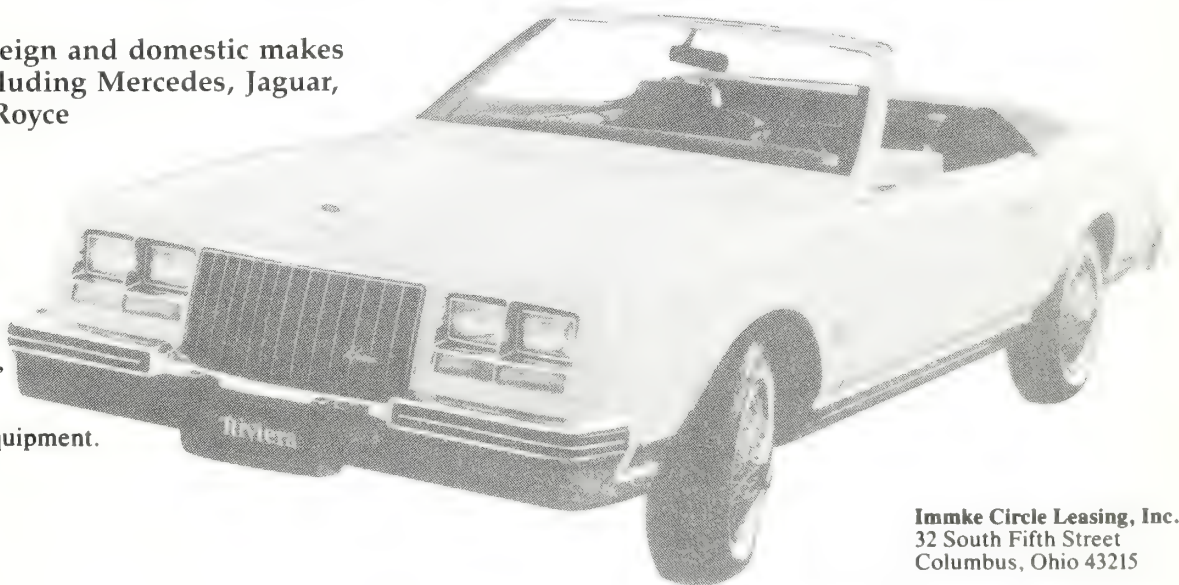
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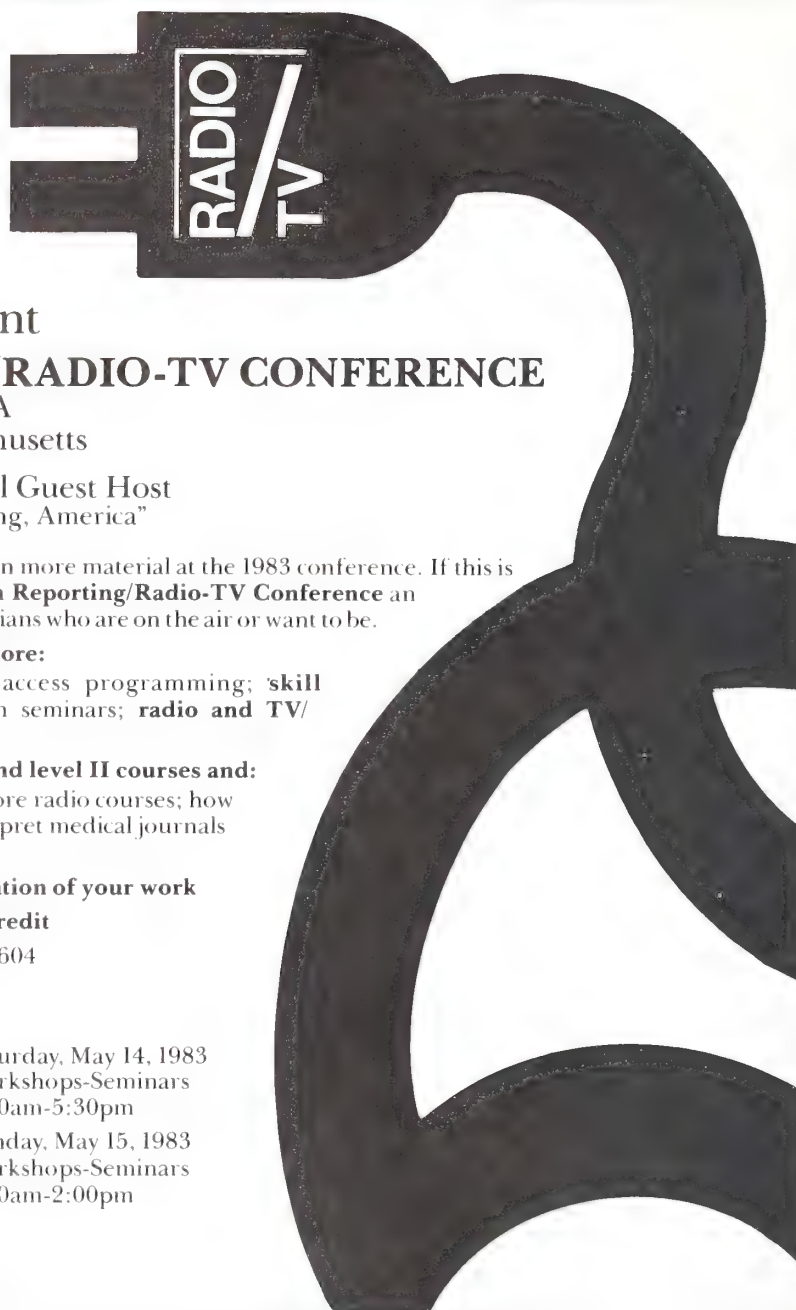
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Friday, May 13, 1983

Workshops-Seminars

7:30am-5:30pm

Saturday, May 14, 1983

Workshops-Seminars

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Sunday, May 15, 1983

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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It further seems to follow that, as non-PPO hospitals see other institutions within their systems benefiting from affiliations with PPOs, they are likely to be encouraged to follow suit. For example, St. Vincent Charity, St. John's and Timken Mercy are subsidiaries of the holding company owned by the Sisters of Charity of St. Augustine, Richfield, Ohio. With both St. Vincent and St. John's belonging to the St. Vincent PPO network, will not Timken Mercy consider either joining the same network or forming one of its own?

Other likely candidates for future affiliation with PPOs are Akron General Hospital, Riverside Methodist Hospital in Columbus, Miami Valley

As non-PPO hospitals see other institutions within their systems, benefiting from affiliations with PPOs, they are likely to be encouraged to follow suit.

Hospital in Dayton, and Christ Hospital in Cincinnati. These hospitals already have shown an interest in joining forces to keep the competitive edge by joining the Voluntary Hospitals of America, and they may seek the further benefits of a larger consumer base by affiliating with PPOs.

Finally, as we examine the future of PPOs, it would seem that if they provide effective wellness and prevention programs, these programs may themselves form a foundation for the growing success of the PPO. The

Langer Report,* which presents in-depth studies of consumer trends, points out that health, as a daily part of life, has won widespread acceptance with consumers. With this new attitude stressing prevention rather than treatment, and with health interest often outstripping knowledge, consumers may well be attracted to the PPO which offers prevention and wellness programs meeting their perceived needs.

In short, if the growing number of PPOs can produce easier access to health care for the consumer/employee, can meet needs for developing healthier life styles and, above all, can show themselves to employers as being truly cost effective, the future of the PPO could be bright, indeed.

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Robert E. Holcomb is a Contributing Editor to the *Ohio State Medical Journal*, and Director of the OSMA's Department of Field Service and Marketing.

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Letters ...to the editor

"Personal Touch" merits personal thanks

To the Editor:

Congratulations to Gina DiBlasio Cummins on such a fine article! "The Personal Touch" was a definite plus for boosting the OSMA-Auxiliary's efforts. My only regret is that the state legislation liaison committee was not mentioned by name. They do the work and without their aid the program would not be as effective or possible. I was delighted to see the monthly publication of the *OSMA Journal* directed at legislation and its efforts and accomplishments, past and present.

And what a joy to see that friendship with a legislator was stressed and encouraged!

My personal thanks.

Sincerely,
/s/ Valerie J. Vollmer
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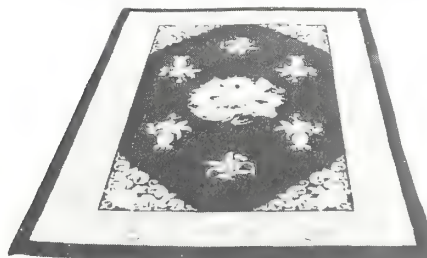
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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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PRESIDENTIAL PERSPECTIVES

Remember the Deadline!

By C. Douglass Ford, M.D.



C. Douglass Ford, M.D.

Besides "Save Your Vision Week" which begins March 6, this month is important to Ohio medicine for one other reason: It is the deadline for the submission of resolutions which will be considered by the OSMA House of Delegates at its Annual Meeting. I draw your attention to this deadline,¹ (1) because I suspect that many members are unaware that the submission of resolutions is an important (although seldom used pathway) to the shaping of association policy.

A sometimes-heard criticism of the OSMA is that it pursues policies that are (1) reactionary, (2) negative, and (3) of a low visibility. These perceptions have some validity in that the association does "react" to the proposals of others, especially when these proposals are perceived to be detrimental to the profession's ability to discharge its responsibilities to patients. Since there are many more proposals which are deemed to be destructive than there are those deemed to be constructive, the association's policies frequently appear to be "negative" to our members, and to the public at large. It can be lonely defending the status quo.

The visibility of the association is lowered, I believe, because most members are more attentive to the multiple determinations they are required to make as physicians. Resolutions, then, offer a quick way for a concerned member to participate in association policy formulation. This

leaves the implementation to those elected to the council and to those appointed to OSMA committees. Of course, any member is eligible to stand for election to one or more of the offices in either the OSMA or the county medical societies.²

Members who wish to establish or modify OSMA policy also have the option of communicating their concerns and goals to their county delegate or alternate delegate. As

Resolutions offer a quick way for a concerned member to participate in association policy formulation . . .

stated, the most immediate route for a member to contribute to policy formulation is to submit a resolution before the deadline¹ and to debate its content before a resolutions committee at the annual meeting in May.

In general, a resolution should address some facet of the association's internal or external affairs. Personally, I do not think it to be appropriate to ask the House to deliberate the affairs of some nonmedical group or disputes which are outside the ken of the federation.

I assume that it is understood that the language in a resolution ought not place the association in jeopardy of litigation from some aggrieved entity or individual. Obviously, the content of a resolution ought not slander or libel anyone. The association's legal staff will review each submitted resolution in order to assist the author in the avoidance of these or other potential embarrassments. Should you submit a resolution (or two), please heed such legal advice, if proffered. Someday, I hope the House will recognize each year's outstanding resolution (good or bad) with the "J.G. Rogers, M.D. Award." Dr. Rogers was the subject of one of the association's more notable resolutions.³

Through the years, the association's members have debated the need for asylums for lunatics, epileptics, inebriates, idiots and imbeciles. In fact, this was a popular subject for resolutions up to the year 1860, and it was considered frequently in the years after that. The members discussed opium abuse and the propriety of offering membership to women physicians in 1880. Expert testimony was a concern in 1855, and the need for a department of vital statistics was discussed in 1853. "Ignorant and irresponsible" persons practicing medicine (1854) and standards of medical education (1856) were not

continued on page 210



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1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) if tachyarrhythmia is being controlled patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. **Central Nervous System:** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

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Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

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Store at room temperature (approximately 25° C).

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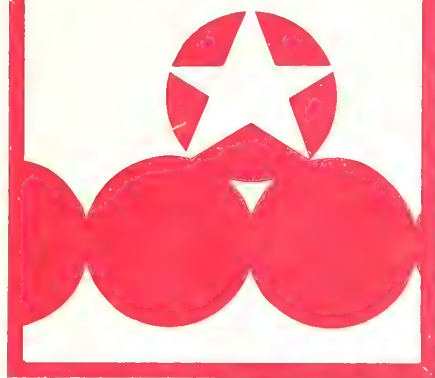
Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

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COLLEAGUES IN THE NEWS



PERRY R. AYRES, M.D., Worthington, Ohio, is the first recipient of the Arthur Dobkin, M.D. Fellowship in the Treatment of Chemical Dependency. The award was presented in January before a meeting of the Summit County Medical Society. Dr. Ayres is chairman of the OSMA Physician Effectiveness Program.

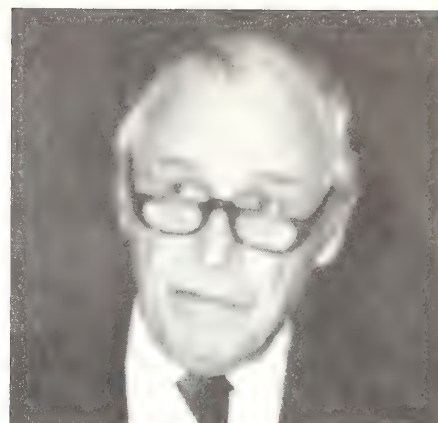
EDWIN H. EIGNER, M.D., Cleveland, was elected to the Board of Overseers at Case Western Reserve University. Dr. Eigner is chairman of the Alumni Fund Campaign for Case Western Reserve University School of Medicine.

RAY W. GIFFORD, JR., M.D., Cleveland, has been invited to serve on the Advisory Committee to the Director of the National Institutes of Health.

LEON GOLDMAN, M.D., Cincinnati, is president of the International Confederation Council for Laser Medicine. Dr. Goldman is director of the Laser Treatment Center and of the Laser Research Laboratory of Jewish Hospital in Cincinnati.

LOUIS D. KACALIEFF, M.D., Akron, was elected president-elect of the American Association of Psychiatric Services for Children.

continued on page 173



Perry R. Ayres, M.D. . . . first recipient of Dobkin Fellowship.



Leon Goldman, M.D. . . . Laser Medicine Council President.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinomas • This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1975. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250 Rx only.

Additional indications: Replacement therapy When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-pubertal cryptorchidism

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"Harmarville's approach to quadriplegics and paraplegics involves diagnosis and treatment by specialists from all rehabilitation disciplines," says Dr. Brenes, Harmarville's spinal cord injury program director.

"Harmarville is one of four hospitals in the Keystone Regional Spinal Cord Injury System pooling efforts to give the greatest possible service—from the accident site to rehabilitation. At any time, Harmarville has 30 to 40 spinal patients.

"In addition to intensive physical restoration, psycho-social, and vocational services, our program emphasizes education, with patients and families in workshops with other patients and families. We also help patients reenter the community, with its architectural and attitudinal barriers."

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- Head injury program for cognitive retraining of brain-injured patients.
- Claims Assessment for Rehabilitation Evaluation and Services (CARES) for returning injured workers to maximum level of function and employment.

For more information on Harmarville, its neuro-spinal program and admission procedures, call Dr. Brenes, 781-5700.



Harmarville Rehabilitation Center, P.O. Box 11460, Guys Run Road, Pittsburgh, PA 15238

Colleagues in the News

(continued)



Jorge Medino, M.D., new President, International College of Surgeons.

JORGE MEDINO, M.D., Willoughby, was elected president of the International College of Surgeons. Dr. Medino's specialty is thoracic surgery.

WILLIAM J. LEWIS, M.D., Dayton, was appointed commissioner to the governing board of the Joint Commission on Accreditation of Hospitals; he will represent the American Medical Association. Dr. Lewis, a family practitioner in Dayton, has been an elected member of the AMA Board of Trustees since 1979.

Officers elected to the medical staff of Lutheran Medical Center, Cleveland, are: **HENRY H. ROENIGK, SR., M.D.,** chief of staff; **JOAN C. PALOMAKI, M.D.,** vice chief of staff; and **JEROME J. BERNER, M.D.,** secretary-treasurer.

RICHARD W. SIDERS, M.D., Toledo, was elected president-elect and **G.B. Mehta, M.D.,** Toledo, was elected secretary-treasurer of the Northwestern Ohio Radiological Society.

FRANK J. WEINSTOCK, M.D., Canton, was elected president of the Society of Geriatric Ophthalmology.

The following officers were elected to the Mansfield General Hospital medical staff: **FREDERICK J. WIECHER, M.D.,** president; **ALBERT TIMPERMAN, M.D.,** vice-president; and **ROBERT GARBER, M.D.,** treasurer.

New hope for arthritics

A combination of powerful drugs has been remarkably successful under experimental circumstances in controlling severe rheumatoid arthritis in a small group of patients, according to a recent issue of the *Journal of the American Medical Association*.

A peripheral vasodilator for treatment of leg cramps cold feet tinnitus discomfort on standing

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Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

LIPO-NICIN[®]/100 mg.

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Ascorbic Acid	150 mg.
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Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

ENT's push a-head with new name

"ENT" (ear, nose, and throat) specialists, members of the second oldest surgical specialty in America, are in the process of an identity change. They are now known as *head and neck specialists*. The 6,500 specialists in the field recently voted for this name change designation to reflect more realistically the present-day scope of their practice.

"Actually the 'ENT' label started becoming inadequate about 20 years ago," said Dr. Loring Pratt, president of the American Academy of Otolaryngology - Head and Neck Surgery. "Over the past two decades the specialty has undergone enormous expansion. Head and neck specialists now treat practically any disorder of the head and neck region, except, of course, eye and brain problems."

Traditional "ENT" problems such as hearing loss, tonsil-throat infections, nasal obstruction, and sinusitis are still important aspects of the specialty. However, head and neck surgeons also

treat cancer and other tumors of the head and neck, fractures of the face and jaw, thyroid diseases, congenital deformities such as cleft lip and palate, skin lesions (of the head and neck), and vertigo. In addition, head and neck specialists perform plastic and reconstructive surgery in the head and neck region.

Like the neurosurgeon, whose expertise is the central nervous system, today's head and neck surgeon is a *regional* specialist, dealing with all disorders above the collarbone, except eye and brain problems. Rapidly improving skills and technology of other specialists (hand, eye, blood vessels, heart) explain why the practice of regionalized surgery has become commonplace.

Technological advances, microsurgery, laser surgery, and the development of new antibiotics are major factors cited by head and neck surgeons for their changing role.

Prescription drug misuse: the preventable problem

"Federal statistics show that prescription drugs make up about 60 percent of the drugs mentioned during drug-related emergency room visits — and about 70 percent of the drugs reported by medical examiners as causes of drug-related deaths," says Emanuel M. Steindler, M.D., director of the AMA's Mental Health program. "While many of these drugs are channeled into illegal uses through diversion and theft at the wholesale level, or are illegally manufactured or imported, a significant amount is reaching the 'street' through dispensing on prescription."

"Physicians who misprescribe generally can be categorized as dishonest, disabled, dated or duped," says Joseph H. Skom, M.D., clinical professor of medicine at Northwestern University Medical School, Chicago, and chairman of the Informal Steering Committee.

But patients also can contribute inadvertently to the misuse and abuse of prescription drugs. Patients with complex medical problems, especially those with longstanding physical or

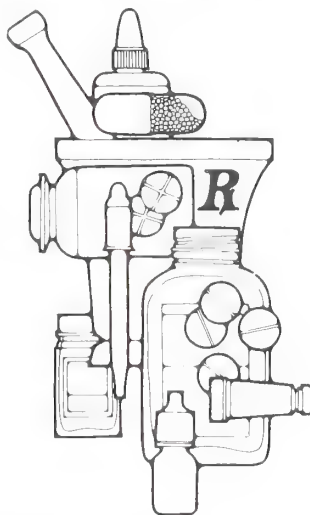
emotional disorders that have not responded to treatment, are particularly vulnerable because drugs are readily available to them, because they associate drugs with relief of problems, and because their personalities may predispose them to

and receive prescriptions from all of them. Even if the drugs have a low abuse potential individually, taking them together may increase their effects.

"To overcome prescription drug abuse, we must first learn the extent of the problem and which drugs are involved in each state," says Mr. Steindler. "Second, we must be able to identify the 'poor' prescribers. Third, we must determine on a case-by-case basis why the physician is a 'poor' prescriber. The PADS model will integrate existing federal, state and local statistics into a format that can be used to make these assessments at the local level."

In an effort to prevent prescription drug misuse, abuse and diversion, the American Medical Association is coordinating efforts to determine the extent of drug diversion at the state level, the drugs involved and the sources of those drugs.

The model plan, called Prescription Abuse Data Synthesis (PADS) will use federal, state and local statistics to make its determination.



excessive use of drugs.

Patients with more than one physician also pose special problems. They typically visit several physicians

Artificial blood may surpass capabilities of ordinary blood

Leland C. Clark, M.D., a Cincinnati physician and biochemist/physiologist with the Cincinnati Children's Hospital Research Foundation has recently reported that his team has made a major advance in his fluorocarbon artificial blood. He has developed a new concept in tailoring the substance to surpass capabilities of ordinary blood.

"I'm not allergic to the word breakthrough," Dr. Clark said on the development of a room-temperature stable artificial blood that does not have to be frozen. Previous substances, which the researcher has been working on since 1966, when he developed the basic fluorocarbon solution, required freezing for stability.

The new substance he calls "fluoroblood," has a nonfrozen shelf life of up to two years.

"We now have a product we believe will completely replace any other artificial bloods — including our own — that can be used to save lives in heart attacks, strokes and emergency conditions."

Artificial blood, basically a fluorocarbon in an emulsion, can carry as much oxygen and carbon dioxide as whole blood, but it doesn't have the components of blood that fight disease.

"A previous drawback to fluorocarbon artificial blood was that you had to thaw it and use it right away," explained Dr. Clark. "You were never certain if you had the same thing every time, because the molecules could grow in size or clump together."

Making the substance stable at room temperature resulted from making the particles very, very small. The original product consisted of the fluorocarbon and an emulsifier to break it down into fine particles.

"To make the new product, we changed the kind of fluorocarbon that's in it and the kind of emulsifier, or surface activation," he said.

"Because we can make these particles one-hundredth the size of a red blood cell, we believe they may go into tiny blood vessels and tissues

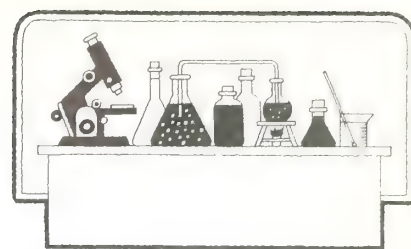
where red blood cells cannot go."

Animal tests, he said, have indicated that an induced heart attack will result in less damaged tissue if artificial blood is administered and supplemented with oxygen.

"I think it also should work against stroke, which is a heart attack of the brain — not enough blood is flowing to a part of the brain. Because you can design it and engineer it, artificial blood may open a whole new way of looking at the treatment of disease."

Dr. Tibor Greenwalt, director of the Paul I. Hoxworth Blood Center in Cincinnati, believes fluorocarbons are not yet ready for clinical applications because "a limiting factor is that the substances are useless if the patients are breathing air. The subjects must be breathing oxygen, which may not be available under emergency conditions in the field."

"I see a usefulness for it (artificial blood) because the particle size is so



much smaller than that of the red cells," he said. "It may prove useful in management of patients with vascular, cerebral and heart infarctions to limit the area of damage under a controlled situation."

Dr. Clark, credited as the inventor of the bubble-defoam heart-lung machine that led to equipment for open heart surgery and for establishing the first intensive-care unit in this country, said his work is not trying to imitate nature.

"We're not trying to make a blood substitute. We're trying to understand the basic mechanisms where oxygen is transported from the lungs to the tissue, then we're trying to improve on that," he said.

"I think blood can be designed, tailored and engineered to meet specific conditions, whether they be a bleeding emergency or heart attack or stroke."

New surgical method treats congenital disease

There has been another advance in the use of intrauterine surgery to treat congenital disease in a fetus, according to a recent issue of the *Journal of the American Medical Association*.

Using a technique called thoracentesis, during which a needle is passed through the fetal chest wall, Robert E. Petres, M.D., Fay O. Redwine, M.D., and Dwight P. Cruikshank, M.D., all physicians from the Medical College of Virginia, Richmond, drained the chest cavity of a 36-week fetus of excess fluid that had caused its lungs to collapse. They performed the procedure a second time after the mother went into active labor a week later, so that the infant could have normal respiratory function immediately after birth.

The infant's condition had been diagnosed by ultrasound before birth as chylothorax, a rare occurrence in

which lymph fluid drains into the fetal chest. Following delivery, the infant was moved to a neonatal intensive care unit where chest tubes were inserted to continue draining fluid from her lungs. She was discharged on the eighth day after birth.

Thoracentesis reduced the likelihood of damage to the fetus from pressure on its chest as it passed through the birth canal, according to the Virginia medical team. Intervention before and during birth also prevented injury to the newborn's lungs from mechanical devices that would have been needed to help her breathe if treatment had been deferred until after delivery, they say.

Neonatal chylothorax carries an overall 25% risk of mortality. The cause is unclear, Petres stated in a separate interview, but the condition is reversible with treatment.

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.



minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

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OHIO MEDICINE AT THE CENTER

OSMA 1983 ANNUAL MEETING

May 13-18, 1983

(All programs are scheduled at the Hyatt Regency/Columbus at the Ohio Center unless otherwise indicated.)

Preliminary Schedule

Friday, May 13

OMPAC BOARD	
Luncheon — Champaign Room	12:00 Noon
EMERGENCY RESOLUTION COMMITTEE	
Luncheon/Meeting — Board Room #2	12:00 Noon
OSMA DELEGATION TO AMA	
Meeting — Fayette Room	1:00 PM
COUNCILOR DISTRICT CAUCUS	4:00 - 5:30 PM
District 1 — Marion Room	
District 5 — Knox Room	
Districts 2, 3, 4, 6, 7, 8, 9, 10, 11, 12 and students	In assigned suites (to be announced)
HOUSE OF DELEGATES	
Registration — Ballroom Foyer	3:00 - 7:00 PM
Sit-down Dinner — Regency Ballroom N	5:30 PM
Opening Session — Regency Ballroom S	7:00 PM
FOLLOWING HOUSE OF DELEGATES	
Reception hosted by the Academy of Medicine of Columbus & Franklin County	Franklin A & B
REFERENCE COMMITTEES	
Breakfast — Regency Ballroom N	7:00 AM
Hearings	8:00 - 11:30 AM
Committee No. 1, Delaware A	
Committee No. 2, Delaware B	
Committee No. 3 & President's Address, Delaware C	
Nominations Committee, Champaign Room	
into Executive Session	1:30 PM
(same rooms as earlier)	
Drafts & Reports	9:00 PM
Prepared and Reviewed by Committees	
OMPAC	
Social Hour & Luncheon	11:30 AM - 1:30 PM
Regency Ballroom N & Regency N Foyer	
PACO PROGRAM	2:00 - 5:00 PM
PACO Medical Computer Systems (computer demonstration) — Madison Room	
MEDICAL MUTUAL & OMIM	5:00 - 7:00 PM
Combined Reception — Marion & Morrow Rooms	
THEATRE PRODUCTION	8:00 PM
"Morning's at Seven" — Players Theatre of Columbus	
AFTER THEATRE PARTY — Marion & Morrow Rooms	10:00 PM

Sunday, May 15

DISTRICT CAUCUS	
Meetings (Reports ready)	9:00 AM
District No. 1 — Marion Room	
District No. 5 — Knox Room	
Districts 2, 3, 4, 6, 7, 8, 9, 10, 11, 12 and students	In assigned suites (to be announced)
HOUSE OF DELEGATES	
Registration — Regency Ballroom S Foyer	11:30 AM
Final Session — Regency Ballroom S	1:00 PM
Sit-down Dinner — Regency Ballroom N	6:00 PM
Resume Final Session (if necessary) — Regency Ballroom S	7:00 PM

Monday, May 16

OTOLARYNGOLOGY	
Scientific Session	8:00 AM - 5:30 PM
Delaware D	
Luncheon	12:00 Noon
Delaware C	
OSMA COUNCIL	
Meeting/Breakfast	8:30 AM
Madison Room	
HEALTH COMMISSIONERS	
Meeting	8:30 AM - 4:00 PM
Morrow Room	
SPORTS MEDICINE	
Meeting	8:30 AM - 4:00 PM
Union A & B	
Luncheon	11:40 AM
Union D & E	
NEUROLOGY	
Scientific Session	8:30 AM - 12:00 Noon
Knox Room	
OHIO COMMITTEE ON TRAUMA, A.C.S.	
Scientific Session	9:00 AM - 12:00 Noon
Union C	
PSYCHIATRY	
Scientific Session	9:00 AM - 4:00 PM
Delaware A & B	
Luncheon	11:30 AM - 1:00 PM
Regency Ballroom N	

continued on next page

Preliminary schedule

continued

UROLOGY

Scientific Session	10:00 AM - 3:00 PM
Champaign Room	
Luncheon	12:00 Noon
Clark Room	

PICO

Shareholders Meeting	10:00 AM
Marion Room	

RHEUMATOLOGY

Luncheon	12:00 Noon
Fayette Room	
Scientific Session	1:00 - 5:00 PM
Madison Room	

EMERGENCY MEDICINE

Meeting	1:00 - 5:00 PM
Union C	

FAMILY PRACTICE

Scientific Session	1:00 - 4:00 PM
Marion Room	

PATHOLOGISTS

Board of Governors	4:00 - 6:30 PM
Clark Room	

NEUROSURGERY

Business Meeting	4:00 - 6:00 PM
Cocktail Hour	7:00 - 8:00 PM
Dinner	8:00 - 10:00 PM
(All Monday events at Columbus Club, 181 East Broad Street.)	

Tuesday, May 17

OPHTHALMOLOGY

Scientific Session	8:00 AM - 5:00 PM
Franklin C & D	
Luncheon	12:00 Noon
Franklin A & B	

HEALTH COMMISSIONERS

Meeting	8:30 AM - 4:00 PM
Morrow Room	

PATHOLOGY

Scientific Session	8:30 AM - 5:00 PM
Union A	
Luncheon	12:00 Noon
Delaware A	

INTERNAL MEDICINE

Scientific Session	8:30 AM - 12:00 Noon
Union E	

NEUROSURGERY

Scientific Session	9:00 AM - 4:15 PM
Union B	
Luncheon	12:15 - 1:30 PM
Fayette Room	

PHYSICAL MEDICINE & REHABILITATION

Luncheon	11:30 AM - 1:00 PM
Champaign Room	
Scientific Session	1:30 - 5:00 PM
Marion Room	
Cocktails	5:30 PM
Clark Room	
Dinner	
Champaign	

COLON & RECTAL SURGERY

Luncheon	12:00 Noon - 1:30 PM
Clark Room	
Scientific Session	2:00 - 5:00 PM
Madison Room	

DERMATOLOGY

Scientific Session	1:00 - 5:00 PM
Union C	

Wednesday, May 18

PLASTIC SURGERY

Scientific Session	8:00 AM - 12:00 Noon
Union B	
Luncheon	12:30 PM
Knox Room	

ALLERGY & IMMUNOLOGY

Scientific Session	8:30 AM - 12:00 Noon
Union A	
Luncheon	12:30 PM
Fayette Room	



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valuable time . . .**



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Your Angina patients could fly coast to coast on the long-acting effects of one 10mg tablet.

Bioavailability findings* of Oral, Sublingual and Chewable Cardilate[®] dosage forms in volunteers demonstrated that the Oral (swallowed) 10mg Tablet provided a 6-hour duration of pharmacologic effect; more than 3 times longer than when given sublingually, or as the chewable Tablet. Cardilate Oral Tablets are recommended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris.

*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

Cardilate[®] (erythrityl tetranitrate) Tablets

INDICATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin

CONTRAINDICATIONS: Hypersensitivity or idiosyncratic reaction to organic nitrates.

WARNINGS: The use of nitrates in acute myocardial infarction or congestive heart failure should be undertaken only under close clinical observation and / or in conjunction with hemodynamic monitoring.

PRECAUTIONS: Use with caution in patients with severe liver or renal disease. Tolerance to this drug, and cross-tolerance to other nitrates, may occur. Cardilate should be given to a pregnant woman only if clearly needed. Caution should be exercised when Cardilate is administered to a nursing woman. Safety and effectiveness in children have not been established

ADVERSE REACTIONS: The most frequent adverse reaction in patients treated with Cardilate is headache. Other adverse reactions occurring are the following: cutaneous vasodilatation with flushing, and transient episodes of dizziness and weakness, plus other signs of cerebral ischemia associated with postural hypotension. Occasional individuals exhibit marked sensitivity to the hypotensive effects of organic nitrates, and severe responses (e.g., nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and / or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION: Oral / Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed

HOW SUPPLIED: TABLETS
(Scored) for ORAL or
SUBLINGUAL USE
5 mg: Bottle of
100 10 mg:
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1000

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Unlike thiazide diuretics, which can provoke serious reductions of serum potassium, INDERAL has been found to maintain or modestly increase serum potassium levels.^{1,2} Therefore, the consequences of hypokalemia—including the threat of ventricular arrhythmias²—may be significantly reduced.

INDERAL acts to reduce catecholamine-induced "spiking" of blood pressure which often coincides with the physical and emotional stress in a hypertensive's life.³ INDERAL reduces elevated heart rate, force of ventricular contraction, and cardiac work load—providing smooth control of hypertension to decrease the risk of related cardiovascular complications. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.)

INDERAL works in a way that non-beta blockers can't—to provide long-term cardiovascular benefits.

INDERAL provides treatment for coexisting angina pectoris or cardiac arrhythmias in addition to reducing blood pressure—for comprehensive protection. What's more, INDERAL is well tolerated, acting with few of the distressing side effects of antihypertensive agents such as methyldopa or reserpine. Impotence, depression, sedation, orthostatic hypotension, and nasal stuffiness are rare. (Please see following page for Brief Summary of Prescribing Information, including side effects of INDERAL.)

Indeed, INDERAL has changed the face of antihypertensive therapy, worldwide. And it continues to do so—with an unparalleled record of clinical efficacy and experience.

INDERAL. It's the kind of protection hypertensive patients need—right from the start.

References: 1. Traub, Y.M., et al.: Clin. Pharmacol. Ther. 28:765 (Dec.) 1980.
2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. 647 (Suppl.):67, 1981.
3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

INDERAL® (PROPRANOLOL HCl)

Comprehensive Cardiovascular Protection

Please see following page for brief summary of prescribing information.

THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

INDERAL[®] (PROPRANOLOL HCl) B.I.D. FOR HYPERTENSION



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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
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Inderal[®] (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS

EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension, paresthesia of hands; arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System:** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculo-mucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

— Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10", contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).
— Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20", contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).
— Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40", contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).
— Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60", contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91). Also in unit dose packages of 100 (NDC 0046-0426-99).
— Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80", contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

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Store at room temperature (approximately 25° C).

INJECTABLE

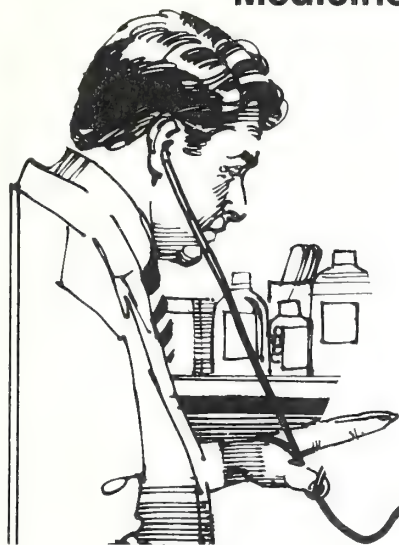
— Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).
Store at room temperature (approximately 25° C).

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Medicine comes face to face with business



Business Coalitions

How healthy are they?

By Gina DiBlasio Cummins

Turn back the clock to a time when worries of health care costs and business coalitions were nonexistent. A physician would examine a patient, administer the necessary treatment and charge from a fee schedule that barely filled a page. It didn't matter that livestock or crops were sometimes given in payment. What did matter was that patients paid when they were expected to — at the time the service was rendered — and each party left satisfied. The market system worked to control costs, though, of course, medical procedures were still relatively simple and technology had not yet had an effect.

What happened over the years that resulted in such great increases in health care costs? That is the question coalitions of health care providers, industry, insurers and government representatives are attempting to

answer. . .and for which they ultimately hope to find a solution.

Two OSMA physicians, John Boyles, Jr., M.D., a Dayton otolaryngologist, and John J. Newton, M.D., a Toledo general practitioner, both knowledgeable on the workings of

Business can no longer be expected to shoulder the burden of high health care costs alone . . .

their community coalitions, share their views on the causes of high health care costs — and on coalitions as a viable solution to lowering these costs.

Both feel business can no longer shoulder the burden alone.

The causes of high health care costs are varied and numerous.

About 40 years ago, medicine began to change dramatically. After World War II, technology boomed — but not without a price tag. Patients found themselves with higher and higher medical bills to pay, so the insurance principle was incorporated into the health delivery system where it worked well — for awhile.

If coalitions hope to successfully lower health care costs in their communities, it seems only reasonable that they cooperate and coordinate their efforts with medicine and other community groups. But even if coalitions include a cross-section of the community, will they be able to singlehandedly control health care costs? Dr. Newton is skeptical. Dr.



The best way to trim health care costs is to develop a business coalition — a system of community health planning with representatives from medicine, hospitals, politics, insurance companies and industry.

John Boyles, Jr., M.D.
Dayton

Boyles is counting on it. But on one thing they agree — it must be done.

"In the '50s and '60s, before the advent of government controls and first dollar coverage type insurance programs, our system of medical care was called 'the private practice of medicine' and it resulted in the best medical care of any group in the world — at affordable prices," notes Dr. Boyles. He explains that trouble started when the financial obligation of the patient was gradually removed, as health care became a "right" of every citizen. "During this time the United States could afford to institute a variety of social programs to cure the ills of our citizenry." In addition, industry could afford to grant its employees increased benefits — one of which was health care. "These all-inclusive insurance programs with complete coverage of costs for both doctor and hospital effectively insulated the patient from all cost consciousness — creating the economic problems we now face."

This escalation of health care costs is evident in several areas — particularly in hospitals. Hospitals now compete by offering patients and physicians newer, more modern equipment, more lavish surroundings and ancillary services. Naturally, this type of competition generates rather than limits cost.

"However, hospitals are not single-handedly attempting to destroy the contract that is the basis of the private practice of medicine. The Blue Shield Advance Plan promises physicians that their financial world will be improved if they take assignment — and therefore no longer deal financially

with their patients. If you stop and analyze this program, it will forbid the private practitioner to deal with patients on an economic basis."

Finally, the overexpansion of hospitals is the most recent development to interfere with the future of private practice. The larger the hospitals, the more ancillary roles they assume in health care delivery. "This needless overexpansion will, of course, encourage the hospitals to move into the primary care specialty and will again isolate and restrict the patient's free choice of physician and hospitals — and the doctor's ability to practice in the most cost efficient manner."

Dr. Newton agrees with Dr. Boyles that these factors have contributed to increased health care costs, but he feels that there are additional causes as well. "Our aging population, booming technology and this country's insatiable demand for maintaining good health all contribute significantly to escalating health care costs."

Now that the problem has been identified, what about a cure?

Dr. Boyles feels that the best way to trim health care costs is to develop a business coalition — a system of community health planning. Representatives from medicine, hospitals, politics, insurance companies and industry, can be educated, oriented to the reality of high medical costs. Consequently, they will work toward the same goal: to cut costs while maintaining quality care."

Dr. Boyles, who has worked extensively with developing the Miami Valley Coalition for Health Care Cost Effectiveness in his community, notes

that his coalition has already attempted:

- To contain health care costs for employers and employees without sacrificing essential health needs.
- To stimulate price and service competition among health care providers and insurers.
- To improve the cost-effective delivery of medical services and control wasteful or abusive practices.
- To encourage healthful lifestyles and enhance wellness among employees.
- To promote affordable health care and good personal health throughout the Miami Valley.

"By using our expertise and clout, we hope to improve the operation of the market as an alternative to expanded government regulation." In addition, the coalition will examine alternatives to the way health care is currently financed and purchased — and the way providers are reimbursed.

"For instance, we must encourage insurance systems that will return to the true insurance principle. Various systems of co-pays, deductibles or prepaid plans should be offered to the consumer so that he may choose the type of health care he desires and full dollar coverage then will be totally eliminated." Dr. Boyles notes that this discussion has led to the development of an Employees Health Care Action Committee in Dayton. This committee, along with other large companies in Dayton, have talked about changing their employees' benefit programs by turning back the clock to a time when employees carried the brunt of health care costs.

continued on page 192

AYERST LABORATORIES ANNOUNCES

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Today's most wanted P₂ analgesic formula...
in today's most wanted form.

TABLETS

ANACIN-3 
ACETAMINOPHEN

with Codeine 15 mg, 30 mg, 60 mg

Each tablet contains acetaminophen and codeine phosphate* as follows:
acetaminophen, 325 mg and codeine phosphate*, 15 mg (1/4 gr)
acetaminophen, 300 mg and codeine phosphate*, 30 mg (1/2 gr)
acetaminophen, 300 mg and codeine phosphate*, 60 mg (1 gr)

*WARNING: May be habit forming.

Please see adjacent page for brief summary of prescribing information.

TABLETS
ANACIN-3[®]
ACETAMINOPHEN
with Codeine 15 mg, 30 mg, 60 mg

Brief Summary (For full prescribing information see package insert.)

Description: Each Tablet Contains Acetaminophen 325 mg, and Codeine Phosphate*, 15 mg Acetaminophen 300 mg, and Codeine Phosphate*, 30 mg Acetaminophen 300 mg, and Codeine Phosphate*, 60 mg

*WARNING: May be habit forming

Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: Drug Dependence: Codeine can produce drug dependence of the morphine type, and may be abused. Dependence and tolerance may develop upon repeated administration. Prescribe and administer with the same degree of caution appropriate to the use of other oral narcotic medications. Subject to the Federal Controlled Substances Act (Schedule III).

Precautions: Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Information for Patients: Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking this drug should be cautioned accordingly.

Drug-Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety, or other CNS depressants (including alcohol) concomitantly with acetaminophen and codeine may exhibit additive CNS depression due to the codeine component. When such therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine.

The concurrent use of anticholinergics with codeine may produce paralytic ileus.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, acetaminophen and codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Nursing Mothers: It is not known whether the components of this drug are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when acetaminophen and codeine are administered to a nursing woman.

Adverse Reactions: Most frequently: Lightheadedness, dizziness, sedation, shortness of breath, nausea and vomiting. More prominent in ambulatory than in non-ambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Others: Euphoria, dysphoria, constipation and pruritus.

Dosage and Administration: Dosage should be adjusted according to severity of pain and response of the patient. However, it should be kept in mind that tolerance to codeine can develop with continued use and that the incidence of untoward effects is dose related. This product is inappropriate even in high doses for severe or intractable pain. Adult doses of codeine higher than 60 mg fail to give commensurate relief of pain but merely prolong analgesia and are associated with an appreciably increased incidence of undesirable side effects. Equivalently high doses in children would have similar effects.

Adults: **Codeine**—15-30 mg (for mild to moderate pain) 60 mg (for moderate to moderately severe pain)

Acetaminophen—300-600 mg

Children: **Codeine**—500 mcg/kg

Doses can be repeated up to every 4 hours.

Full directions for use should be consulted prior to administering or prescribing.

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Business Coalitions

continued

Dr. Boyles feels that shaving high hospital costs is another important issue the coalition has addressed. "We must strive to return the hospital to its basic role of caring for the acutely ill. There is no reason for hospitals to be in drug dependency programs, ambulatory care centers, alcohol rehabilitation programs, real estate (physician offices) or other activities unrelated to the care of the acutely ill."

Not everyone sees coalitions as "the answer," however. Dr. Newton has reservations about how effective business coalitions are in lowering health care costs.

"In our community the coalition consists of a group of area corporations that have joined together to try to impact health care costs. The business coalition has positioned itself to interact with various groups in the community, (physicians, hospital, labor, insurance carriers) to obtain specific information regarding health care costs. With this information, they attempt to make decisions and thus orchestrate approaches to health care cost containment that will be most helpful to them." He says that the goals of appropriate facility utilization, hospital capital expenditure control, and subscriber insurance package redesign have been generally accepted by the business and provider committees.

"My concern in this effort is that, while these goals are valid and generally supported by all as desirable, they are not the answer to the problem of escalating health care costs — and, so far, no one has effective solutions. It is important that we not place ourselves (physicians) in the position of accepting responsibility for

controlling health care costs via utilization, hospital capital expenditures, and insurance package redesign alone, because these are not the real drivers of health care costs, as noted earlier. Since the real forces of aging population, arriving technology, and high health interest among the general population are the cost drivers, it is important that we not assign ourselves the task of solving cost concerns by only addressing the previously stated goals. Banking on simply tightening the system is probably not going to do the job in the long term, and we should avoid that trap along with its attendant criticism if it fails."

Dr. Newton feels that the causes of rising health care costs are very complex and are best addressed by a true coalition composed of all the appropriate groups with each group having input to the process and the decisions. "This sort of coalition is now in place. The AMA business, labor, hospitals, insurance carriers, and others are working constructively on a national health policy agenda for the American people which may give us some good direction in the next year or two. In the meantime, it is important that we make our best efforts in those areas where can influence change. At the same time, it must be recognized that if health care costs do not deescalate permanently, it is not because we did not carry out our tasks."

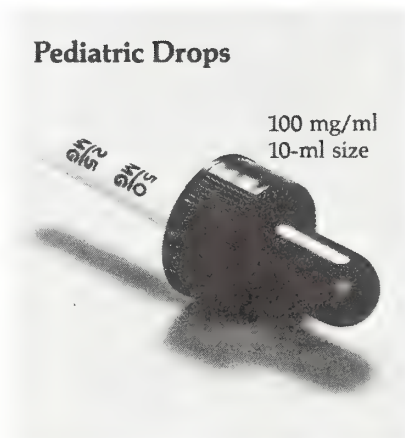
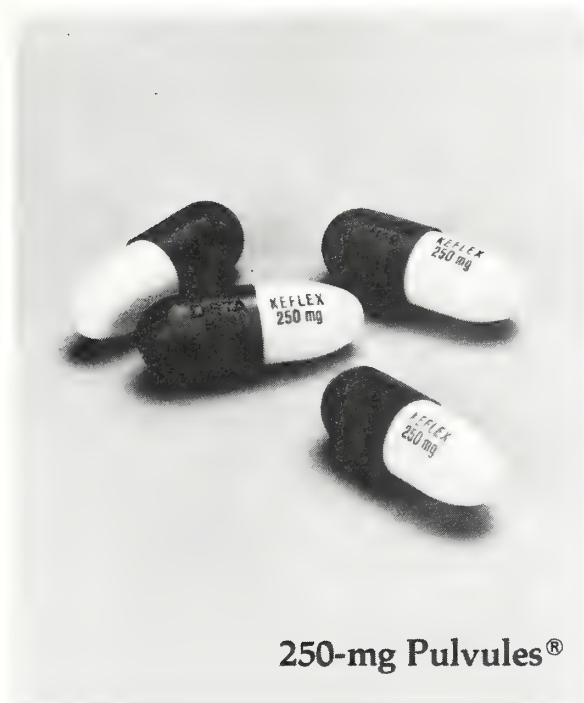
Gina DiBlasio Cummins is Editor of Synergy, and a staff writer for the Journal

While the coalition's goals are valid and generally supported by all as desirable, they are not the answer to the problem of escalating health care costs . . .

John J. Newton, M.D.
Toledo



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The 1983

OSMA ART and CULTURE COMMITTEE'S

Photographic Exhibit



"Comrades" by Marvin Aronoff, M.D., Cincinnati

The Ohio State Medical Association's Art and Culture Committee will sponsor a photographic exhibit and competition. The 1983 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1983 Annual Meeting, Columbus, where the entries will be displayed. Winners will not necessarily appear on future Journal covers.

Photographs may be entered in two divisions: Black and White, and Color.

Entries must be in print form (8" x 10" or 11" x 14") in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a \$10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

Name _____
 If Nonmember, Spouse's Name _____
 Street _____
 City _____ State _____
 County _____ Zip _____
 Telephone _____

Information about photograph:
 (provide as much as possible)

Camera _____	Lens _____
Speed _____	Aperture _____
Subject _____	Film Type _____
Date _____	Time of Day _____
Title _____	

Division: ☐ B & W

☐ Color

Processing/Printing:

☐ Professional

☐ Self

Mail or hand carry the photograph, entry form and \$10 entry fee (make checks payable to The Ohio State Medical Association) to: The Ohio State Medical Association Photographic Exhibit, 600 S. High Street, Columbus, Ohio 43215. All entries must be received no later than April 12, 1983.



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See next page for brief summary of prescribing information.

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- Measured against 15, 30 and 60 mg doses of codeine phosphate in a double-blind study of 287 patients, 400-mg doses of ibuprofen proved "significantly better than codeine on almost all pain intensity, degree of relief and duration of analgesia parameters."²
- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.³
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."⁴

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- better tolerated than aspirin
- no narcotic risk, red tape, records

Acetaminophen + codeine combinations

- combined drugs act partly through central opioid pathways
- virtually no treatment of the inflammatory component
- combined side effects of two drugs—warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
- narcotic precautions required

- matchless economy in a modern NSAID

References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): *Drug Treatment of the Rheumatic Diseases*, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: *Canad Dent Assoc J* 46:433-439, 1980.
3. Selwyn P and Giles AD: *Br Jrl of Clin Practice*, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgesc. Pg 87-90, 1980.
4. Taina E: *Curr Med Res Opinion*, 7:423-428, 1981.



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And Rufen® Measures Up Best

RUFEN® (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see **WARNINGS**). **WARNINGS:** Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see **CONTRAINDICATIONS**). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the **ADVERSE REACTIONS**.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen, caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin: Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see **PRECAUTIONS**). *Incidence 3% to 9%.

Incidence less than 1 in 100. **Gastrointestinal:** gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see **PRECAUTIONS**). **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see **CONTRAINDICATIONS**). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. **Gastrointestinal:** pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photo-allergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

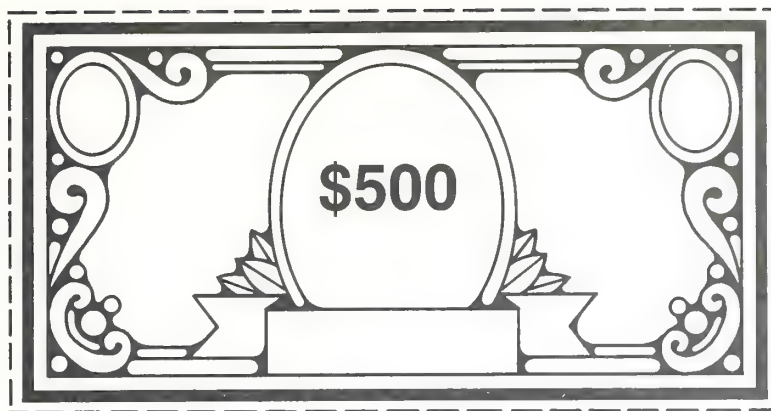
OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.



The Health Care Rebate

By Karen S. Edwards

Human Resource officials at Zanesville's Good Samaritan Hospital smacked the papers in front of them — papers informing them of 40% increases in the health care premiums they carried for their nearly 1,000 employees. This was the last straw, they agreed. Increases in premiums already had been accelerating at outstanding rates and more increases would, doubtless, lie ahead in the future. Something would have to be done.

It wasn't that the hospital was unfamiliar with escalating health care costs. As a provider, they knew all about the price tag that accompanies good medical care. But the pinch was getting tighter . . . and even the employees weren't happy.

"We conducted an employee attitude survey three years ago which showed very negative reactions in the area of health insurance," explains Carol Hurst, Vice President, Human Resources, Good Samaritan Hospital.

Employees were especially critical of those who were abusing their insurance.

"There was a general feeling that good health care managers — those who took care of themselves, and used health care wisely — were ultimately paying for those who were not managing their health care very well."

There was a general feeling that good health care managers were ultimately paying for those who were abusing their insurance.

About this time, publicity was being released on a California program which enabled employers to put money into retirement programs, for those employees who were not using all of their health insurance dollars.

The story seemed to be just what Good Samaritan needed to hear. Why not arrange something similar for their

employees — something that would provide the necessary coverage for all employees — and yet reward those who *were* taking care of themselves?

No wonder, then, that with the new premium increase before them, and the recognition that this was a sensitive area with their employees, Good Samaritan Hospital began to look for other solutions to their insurance problem.

The "Stay Well" program evolved . . . a unique plan whereby employees could pay an annual \$200 fee for a single policy (\$500 for family), and at the end of the year those who had not utilized the extent of their annual deductible, could be refunded, in cash, for the amount of deductible not used.

The plan was accepted by everyone — except the insurance companies. None of them wanted to buy the program. Undaunted, the hospital self-insured, and called on Blue Cross to administer the claims.

"Within the first year, the hospital's major medical costs were reduced by as much as 50%," Hurst says. And

continued on page 199

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The Health Care Rebate

continued

rebates totaling over \$100,000 were returned to those employees who had used their benefits wisely.

Teaching employees about the wise use of benefits is one responsibility which Good Samaritan takes very seriously.

"We try to educate employees to seek only the medical care they need, and then to seek it in the least costly setting," Hurst explains.

In order to accomplish this, the hospital offers a full range of medical education programs — both to the staff and to the community.

"In our parenting classes, for example," Hurst says, "we tell the parents not to wait until there is a disaster before taking their child for

"We try to educate employees to seek only the medical care they need, and then to seek it in the least costly setting . . ."

medical help." Regular pediatric visits can help allay if not avoid, high-priced emergency room visits.

Another way to avoid those costly emergency calls is learning how to recognize illness — and when to see a physician.

"We've recently started a 'brown-bag' lunchtime series of medical educational programs which have proved to be as popular with the community as they are with our employees," Hurst says.

Every other month, a staff physician or nurse explores the nature of a specific illness — how to recognize its symptoms, what kind of home care can be done, and when to consult a physician. Other programs explain the reasons for various medical tests, when and why they are ordered, and what a patient might expect from them.

continued on page 209

BRIEF SUMMARY PROCARDIA® CAPSULES

For Oral Use

(nifedipine)
INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not compatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for
your patients—having fewer anginal attacks, taking fewer
nitroglycerin tablets, doing more, and being more productive
once again.

Side effects are usually mild (most frequently reported are
dizziness or lightheadedness, peripheral edema, nausea,
weakness, headache and flushing, each occurring in about 10%
of patients, transient hypotension in about 5%, palpitation in
about 2% and syncope in about 0.5%).

Older men with angina and
less than 10 years of experience
with the disease. The experience
is representative of many
angina patients who do not
respond to the usual degree.

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for the varied faces of angina

* Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these

PROCARDIA[®]
(NIFEDIPINE) Capsules 10 mg



PROCEEDINGS OF THE COUNCIL

November 13, 1982

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, November 13, 1982, at the Marriott Inn North, 6500 Doubletree Drive, Worthington, Ohio.

Those present were: C. Douglass Ford, M.D., Toledo; S. Baird Pfahl, Jr., M.D., Sandusky; Stewart B. Dunsker, M.D., Cincinnati; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Edward G. Kilroy, M.D., Cleveland; J. James Anderson, M.D., Youngstown; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; Frank Papay, Medical Student Section, Tallmadge; Terrance M. Miller, Esq., Columbus; Oscar W. Clarke, M.D., Chmn., AMA Delegation, Gallipolis; W.J. Lewis, M.D., AMA Board Member, Dayton; John H. Ackerman, M.D., Dir., Ohio Dept. of Health, Columbus; and Perry R. Ayres, M.D., Chmn., Committee on Impaired Physicians, Worthington.

Those present from the OSMA Staff were: Hart F. Page, CAE; Herbert E.

Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Gail E. Dodson; Robert E. Holcomb; David C. Torrens; Carol W. Mullinax; Eric Burkland; Michael L. Bateson; Louis N. Saslaw; Catherine M. Costello, Esq.; and William E. Fry.

Announcements by President Ford

The meeting was called to order by President Ford.

Dr. Ford reviewed the October 13, 1982 meeting of the officers with the Deans of medical schools.

Mr. Page presented a letter dated October 20, 1982 from Dr. Ray W. Gifford, Jr., President of the Academy of Medicine of Cleveland, nominating Dr. Edward G. Kilroy for President-Elect of OSMA.

The minutes of the September 11, 1982 meeting of the Council were approved.

Mr. Page presented to the Council a proposal from the Summit County Medical Society that the OSMA bill its members for renewal of OSMA and AMA membership. The Council approved a one-year pilot program, contingent on assurance from the Summit County Medical Society that it understands that the members must renew both county and state association membership. It is the understanding of the Council that those who do not renew both county

and state memberships will be dropped from membership in both Summit County Medical Society and OSMA.

Mr. Page reported on a communication from Gerald J. Brook, M.D., dated November 8, 1982, with regard to a plan for care of unemployed people who are without resources.

The Council approved the concept in principle and asked the staff to bring a proposal to the December meeting of the Council.

Administration

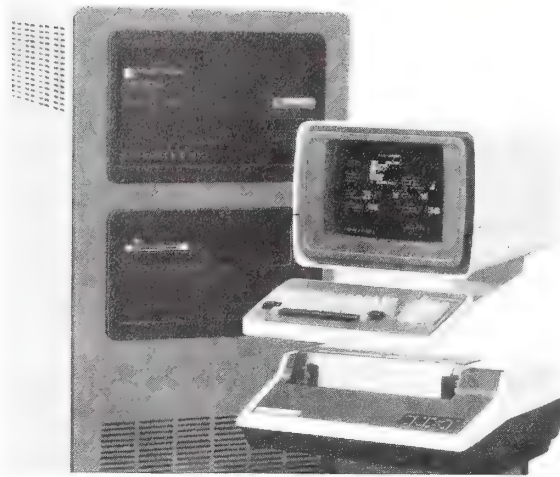
The Council recommended the following members for the Board of Directors of the Ohio Medical Political Action Committee: Second District - John H. Boyles, Jr., M.D., Dayton; Fifth District - Theodore J. Castele, M.D., Cleveland; Tenth District - William T. Paul, M.D., Columbus.

Medical Student Liaison Committee

— Mr. Saslaw and Mr. Papay discussed the minutes of the October 26, 1982 meeting of the Medical Student Liaison Committee and the results of a Committee survey of 871 medical students on the subject of student financial aid.

With regard to a proposed student loan program, the Council endorsed the program in principle and referred the matter to the Committee on

continued on page 225



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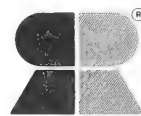
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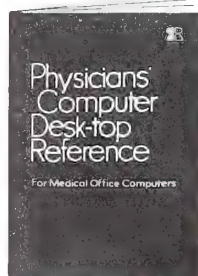
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If you are an Ohio institution sponsoring a CME program and wish to have it publicized in the Journal, please send all pertinent information to: Continuing Education Department, The Ohio State Medical Association, 600 S. High St., Columbus, Ohio 43215.

March

PSYCHIATRY FOR THE NON-PSYCHIATRIST — AN UPDATE: March 31; The Holiday Inn, I-75 & Route 55, Troy; sponsor: Dettmer Hospital; 7 credit hours; fee: \$60; contact: Gerard F. Wolf, M.D., 145 Sunset Drive, Piqua 45356, phone: 513/773-8323.

April

PEDIATRIC UPDATE — 1983: April 8-9; Quaker Square Hilton Inn, Akron; sponsor: Children's Hospital Medical Center of Akron; 9 credit hours; fee: \$100; contact: Max E. Griffin, M.D., 281 Locust Street, Akron 44308, phone: 216/379-8790.

FEMALE URINARY INCONTINENCE: April 9; Stouffer's Inn on the Square, Cleveland; sponsor: Case Western Reserve University School of Medicine; 6 credit hours; fee: \$50, \$20 for allied health professionals; contact: Martin Resnick, M.D., 2065 Adelbert Road, Cleveland 44106, phone: 216/444-3009.

CRITICAL CARE SYMPOSIUM: April 13-15; Hollenden House, 610 Superior Avenue, Cleveland; sponsor: Case Western Reserve University School of Medicine; 14 credit hours; fee for lectures only: \$250, \$165 for nurses and allied health professionals; fee for skills lab: \$195; contact: Marilyn Lariche, 2065 Adelbert Road, Cleveland OH 44106, phone: 216/444-3875.

CONTEMPORARY CONCEPTS IN OTOLARYNGOLOGY: April 30-May 6; Caneel Bay Resort, St. John, U.S. Virgin Islands; sponsor: University of Cincinnati Medical Center; cosponsor: Communicative Disorders Foundation; 30 credit hours; contact: Ms. Robbie Cornelison, Department of Otolaryngology and Maxillofacial Surgery, University of Cincinnati Medical Center, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4155.

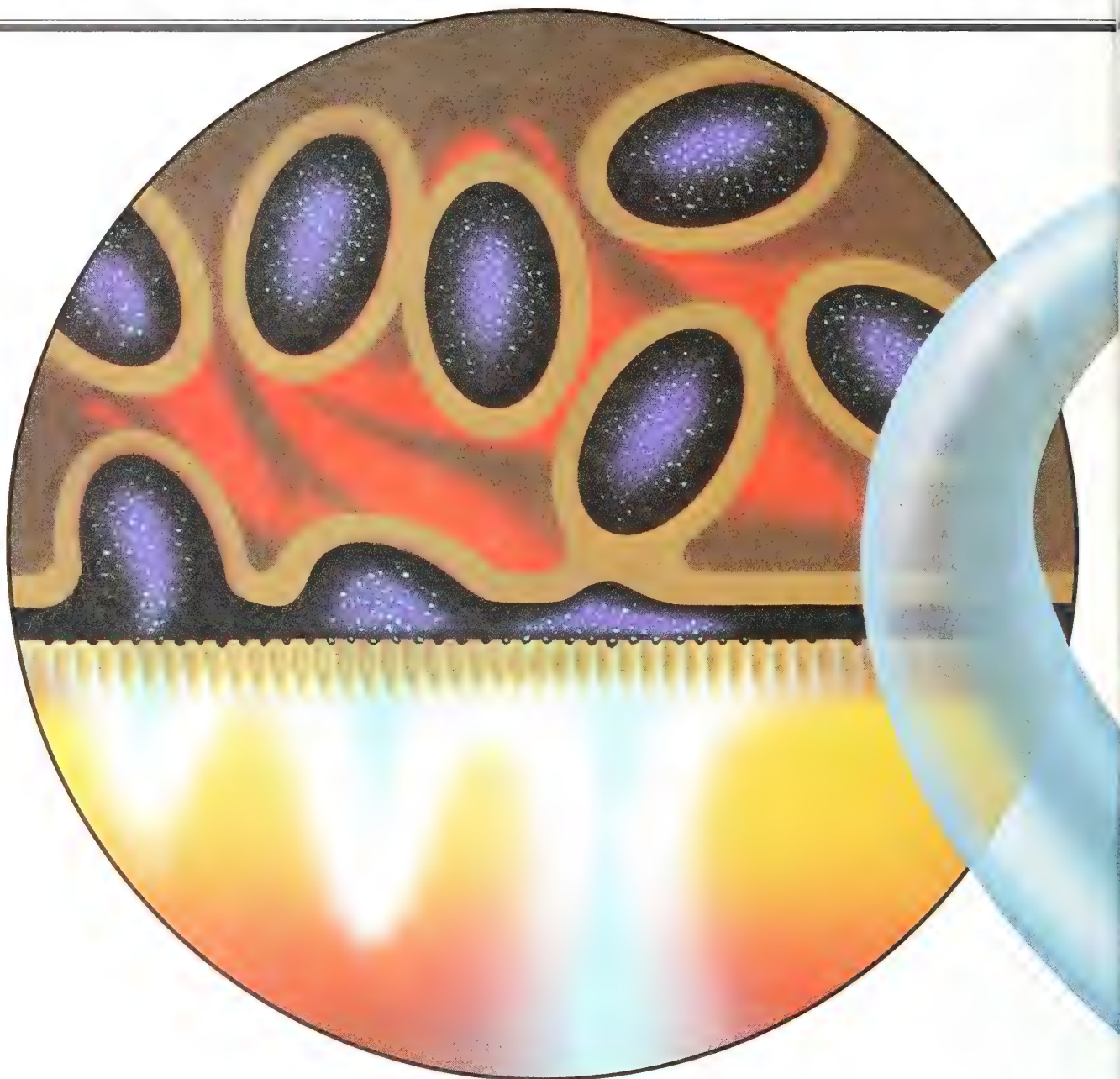
May

MEDICINE 1983: May 4-7; Bond Court Hotel, Cleveland; sponsor: Case Western Reserve University School of Medicine; 23-26 credit hours; contact: Mr. Frank Carlozzi, 2065 Adelbert Road, Cleveland 44106, phone: 216/444-3164.

CURRENT ISSUES AND TRENDS IN APHASIA TREATMENT: May 16-18; Stouffer's Cincinnati Towers, Cincinnati; sponsor: University of Cincinnati Medical Center; 16 credit hours; contact: D. H. Air, Ph.D., Division of Audiology and Speech Pathology, University of Cincinnati Medical Center, Mail Location #780, Cincinnati 45267, phone: 513/872-5353.

TWENTY-FIFTH ANNUAL REFRESHER COURSE IN DIAGNOSTIC ROENTGENOLOGY: May 23-27; Drawbridge Inn, I-75 at Buttermilk Pike, Ft. Mitchell, Ky; sponsor: University of Cincinnati College of Medicine; cosponsor: American College of Radiology; 37 credit hours; fee: \$325; contact: Harold B. Spitz, M.D., University Hospital, 234 Goodman Street, Cincinnati 45267, phone: 513/872-4396.

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New discoveries in receptor research have stimulated the search for endogenous brain substances that may be involved in the mediation of anxiety.¹⁻⁵ It has been further theorized that these substances may act as ligands that bind to the same or similar sites as do benzodiazepine molecules^{5,6}—binding sites early identified with the use of ³H-diazepam.^{5,7} These binding sites are now postulated to be benzodiazepine receptors, since the ability of benzodiazepines to bind with the sites appears to correlate with their clinical effects.^{2,4,7,8}

Present investigations into clinical relevance of binding sites. Laboratories at Roche have conducted research to identify and isolate substances that may prove to be endogenous ligands, but no definitive identification has yet been made. Researchers are also studying substances which do not bind, but rather interact with the benzodiazepine binding sites—most notably gamma-aminobutyric acid (GABA)—and are postulated to mediate certain pharmacologic and clinical benzodiazepine effects.^{2-4,9,10}

Under especially intense investigations are the GABA receptors and the benzodiazepine binding sites themselves—apparently constellations of closely linked but not identical structures.⁸

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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500.* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25* and in boxes containing 10 strips of 10.*

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701

†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

References: 1. Tallman JF *et al: Science* 207:274-281, Jan 18, 1980. 2. Bunney WE Jr: *Psychiatr Ann* 11:11-15, Jan 1981. 3. Davis JM *et al: J Clin Psychiatry* 42(11) Sec 2:4-14, Nov 1981. 4. Study RE, Barker JL: *JAMA* 247: 2147-2151, Apr 16, 1982. 5. Braestrup C, Nielsen M, Olsen CE: *Proc Natl Acad Sci USA* 77:2288-2292, Apr 1980. 6. Bosmann HB, Case KR, DiStefano P: *FEBS Lett* 82:368-372, Oct 1977. 7. Braestrup C, Albrechtsen R, Squires RF: *Nature* 269:702-704, Oct 20, 1977. 8. Snyder SH: *Psychosomatics* 22:986-989, Nov 1981. 9. Rickels K: *J Clin Psychiatry* 42(11) Sec 2:40-44, Nov 1981. 10. Haefely WE: *Br J Psychiatry* 133:231-238, Sep 1978.

Obituaries

RAYMOND B. CAGNINA, M.D., Strongsville; Università di Messina, Messina, Italy, 1936; age 77; died December 15, 1982; member OSMa and AMA.

GUTHER EHLERS, M.D., Centerville; University Parana Curitiba, Parana, Brazil, 1952; age 55; died December 3, 1982; member OSMa and AMA.

JOHN S. FUNG, M.D., Columbus; University of Michigan Medical School, 1945; age 66; died December 17, 1982; member OSMa and AMA.

GREGORY GRESSEL, M.D., Hamilton; University of Cincinnati College of Medicine, 1946; age 62; died October 15, 1982; member OSMa and AMA.

SAMUEL HANTMAN, M.D., Cleveland; Case Western Reserve University School of Medicine, 1926; age 83; died December 9, 1982; member OSMa and AMA.

ILONA L. KASA, M.D., South Deerfield, Massachusetts; University of Debrecen, Hungary, 1940; age 73; died December 20, 1982; member OSMa.

ZELIQUE KATZ, M.D., Dayton; Ohio State University College of Medicine, 1947; age 61; died December 12, 1982; member OSMa and AMA.

SIDNEY KROHN, M.D., Cleveland; Ohio State University College of Medicine, 1944; age 66; died January 8, 1983; member OSMa and AMA.

continued on page 209



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Chairman: **Hong I. Seung, M.D.**, Clinical Assistant Professor, Otolaryngology-Head and Neck Surgery, West Virginia University School of Medicine, Morgantown, West Virginia. Senior Staff, Wheeling Hospital and Ohio Valley Medical Center, Wheeling, West Virginia

Speakers: **Joseph R. Bianchine, M.D.**, Professor and Chairman, Department of Pharmacology; Professor of Medicine, Ohio State University, College of Medicine, Columbus, Ohio.

Thaddeus S. Danowski, M.D., Clinical Professor of Medicine, University of Pittsburgh, School of Medicine; Director of Medicine, Shadyside Hospital, Pittsburgh, Pennsylvania.

Heinz F. Eichenwald, M.D., Professor and Chairman, Department of Pediatrics, University of Texas, Health and Sciences Center, Dallas, Texas.

Michael Glasscock III, M.D., Clinical Professor of Otolaryngology, Vanderbilt University, School of Medicine, Nashville, Tennessee.

Bong H. Hyun, M.D., D. Sc., Professor of Pathology, Rutgers Medical School; Director, Department of Pathology, Muhlenberg Hospital, Plainfield, New Jersey.

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Obituaries

continued

MOSES MARKS, M.D., Cleveland; University of Toronto Faculty Medicine, Toronto, Ontario, 1923; age 81; died January 5, 1983; member OSMA and AMA.

FLOYD S. MOWRY, M.D., Cleveland; Case Western Reserve University School of Medicine, 1916; age 92; died December 31, 1982; member OSMA and AMA.

SHARAD MULTANI, M.D., Toledo; B.J. Medical College, Gujarat University, Ahmedabad, Gujarat, India, 1962; age 47; died January 5, 1983; member OSMA.

MYER S. MUSKAT, M.D., Marietta; University of Cincinnati College of Medicine, 1922; age 86; died January 3, 1983.

SAMUEL RICH, M.D., East Liverpool; Jefferson Medical College; Thomas Jefferson University, 1910; age 93; died December 15, 1982; member OSMA and AMA.

ROBERT BRYAN ROBERTS, M.D., Dayton; University of London, London, England, 1957; age 49; died January 16, 1983; member OSMA and AMA.

WILLIAM D. ROBERTS, M.D., Dayton; Ohio State University College of Medicine, 1951; age 62; died November 12, 1982; member OSMA and AMA.

MINER W. SEYMOUR, M.D., Columbus; Ohio State University College of Medicine, 1937; age 69; died January 2, 1983; member OSMA and AMA.

CALVIN G. SKINNER, M.D., Middletown; College of Medicine, University of Cincinnati, 1938; age 69; died November 24, 1982; member OSMA and AMA.

HARRY P. ULICNY, M.D., Fostoria; Ohio State University College of Medicine, 1941; age 73; died December 29, 1982; member OSMA and AMA.

JAMES T. VILLANI, M.D., Akron; Case Western Reserve University School of Medicine, 1925; age 82; died December 12, 1982; member OSMA and AMA.

HIRAM B. WEISS, M.D., Cincinnati; University of Cincinnati College of Medicine, 1915; age 92; died December 1, 1982; member OSMA and AMA.

ALBERT WILD, M.D., Alliance; University of Maryland School of Medicine, Baltimore, 1920; age 92; died January 11, 1983; member OSMA and AMA.

The Health Care Rebate

continued

But Good Samaritan doesn't end its "Stay Well" programs there. The hospital offers exercise programs, slimnastic workshops and lunch walks.

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Morale, too, has increased.

"We've given the message that the hospital cares how health care dollars are spent, and that we are aware of the need for controlling health care costs," Hurst continues.

That makes for conscientious employees — conscientious *healthy* employees — and in the war against rising health care costs, that may be half the battle.

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.

Answers to crossword

ANSWERS TO DI GEORGE SYNDROME CROSSWORD

ACROSS: 1. Cardiac, 4. Ectopic, 8. AC, 9. Agora, 10. Roe, 11. Oar, 12. Also, 14. Dot, 5. Cower, 16. High, 20. Can, 21. Fourth, 22. TB, 23. T cells, 26. Film, 27. Tattoo, 28. Eyes, 30. Hypoplasia, 34. No, 36. Micrognathia, 37. Do.

DOWN: 1. Coanal, 2. DiGeorge, 3. Aortic, 4. Echo, 5. Third, 6. Parathyroid, 7. Cleft, 13. Twenty-two, 17. Low, 18. Thymus, 19. Eat, 20. Costly, 24. Emetic, 25. Boil, 28. Exam, 29. USMA, 30. HMO, 31. Fan, 32. Pit, 33. And, 35. 00.

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President's Page

continued

overlooked, either. The ethics of advertisements in newspapers and "private handbills" was an issue in 1869. The malpractice problem was an issue in 1861, 1877, 1888, and, as I recall, in 1975. In 1874, they debated the "evils of intoxicating drink," and the "excessive use of alcohol as a medicine." Licensure, ecology, foreign physicians. . . all were addressed before the turn of the century. Third-party payors and "contract medicine" were first debated in 1905, and again in 1920 (our predecessors did not approve).

Many of these issues have recurred over the years because they reflect (as they should do) concerns of the membership. It is a bit frustrating that some problems do not always yield solutions. Nevertheless, member input — by way of resolutions — has become a venerable institution in and

of itself — and I invite your contributions. Just remember the deadline!¹

REFERENCES

- (1) March 14, 1983.
- (2) The format of establishing the House of Delegates, the Council, and the Councilor districts was adopted in 1902. There were ten councilor districts formed at that time.
- (3) Resolved: "That the thanks of this society, as well as the good wishes of all the good citizens in the land, are eminently due to our venerable fellow member, J.G. Rogers, M.D., of New Richmond, Ohio, for the skillful manner in which, on the morning of the 27th of April, 1822, he assisted into this world Ulysses Simpson Grant, the Commander of the

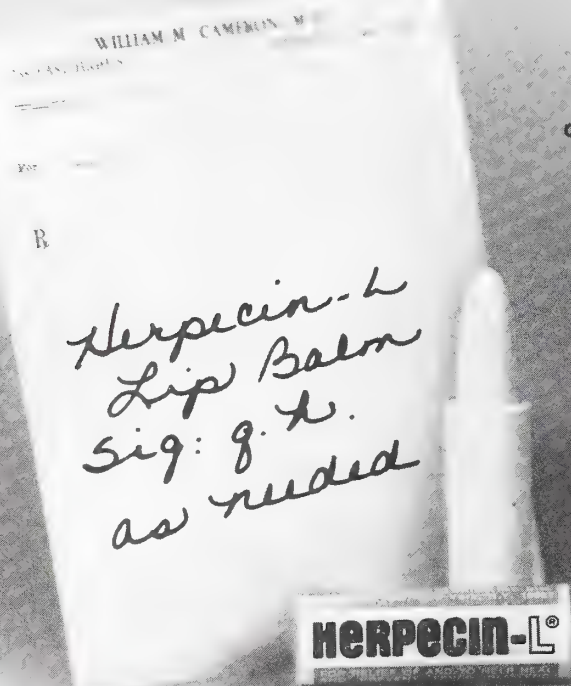
American Armies, the hero of Vicksburg, and the predestined destroyer of the great rebellion." June 21, 22, 1864, Ohio White Sulphur Springs.

How marvelous is technology?

I do not wish to denigrate or dispraise the technical marvels of modern medicine, which no doubt have saved lives and shortened terms of illness. Yet, I cannot help wonder how much of this new equipment is a supplement to the doctor's craft, and how much is becoming simply a substitute for it. For I do not think there can ever be an adequate substitute for the healing art.

— Sydney J. Harris, *Chicago Sun-Times*
September 3, 1982

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3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

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(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

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6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

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"2.Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5.Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

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12. **EDITORIAL ASSISTANCE.** Ms. Carol J. Wiley, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic

therapy. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance.

Adverse Reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis; dizziness, vertigo, paresthesias, headache, xanthopsia; leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia; purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis) (cutaneous vasculitis), Lyell's syndrome (toxic epidermal necrolysis). Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. Other adverse reactions include hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, impotence. Whenever adverse reactions are moderate or severe, chlorthalidone dosage should be reduced or therapy withdrawn.

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CLINICAL NOTES

Edited by Karen S. Edwards

Primary Reading Epilepsy

In a study of primary reading epilepsy (PRE), a subject was asked to read material of increasingly complex subject matter, including: (a) items of general interest from popular

magazines (b) magazine articles presented in an order of increasing complexity, concerning sports, national politics, world economy and an editorial essay, and (c) technical journals from an EEG journal. A number of low-voltage focal spikes and sharp waves in the left hemisphere were recorded throughout testing. The discharges were maximal when the subject was reading the editorial essay and the EEG journal article.

While one might argue that the seizures were triggered by nonspecific factors, such as mental fatigue and emotional reactions — such as frustration — during testing, the subject was able to perform challenging mental calculations and complex nonverbal tests without experiencing any seizures.

The observations point to the fact that seizures in this patient were triggered specifically by complex cerebral activity, associated with language functions. Clearly, this case represents the complex variety of PRE,

but the exact importance of the EEG findings of PRE awaits further clarification.

Archives of Neurology
January, 1983, Volume 40, Number 1
pgs. 39-41

Treating Phobias

In this article, behavior therapy — a widely accepted form of treatment, particularly in alleviating phobias — was compared with supportive psychotherapy during a 26-week treatment trial of patients with agoraphobia, mixed phobia or simple phobia. The authors' expectation was that behavior therapy would be superior to supportive psychotherapy, because it focuses systematically on phobic situations, and is more structured toward helping patients confront these situations.

Contrary to these initial
continued on page 229

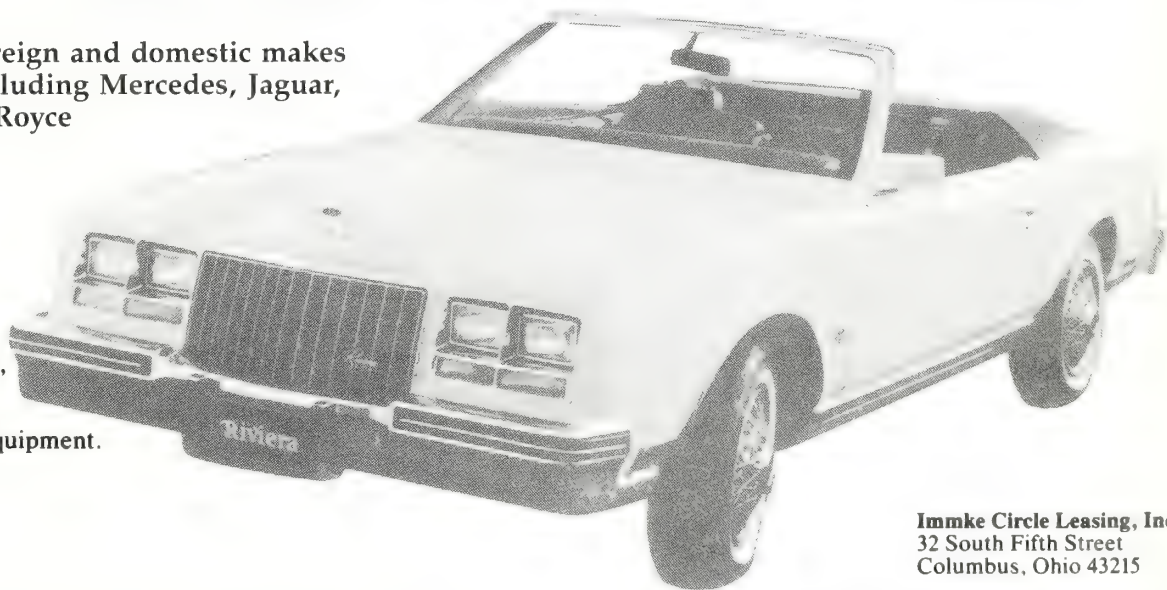
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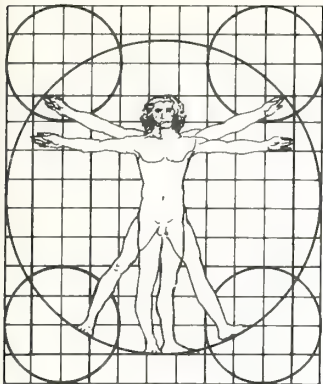
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CLINICAL & SCIENTIFIC

A MEDICAL STUDENT LOOKS AT CROHN'S DISEASE: THE MYSTERY AND THE CHALLENGE

Maria Regina Coccia, Ph.D.

John J. Ferrara, M.D.

Edward W. Martin, Jr., M.D.

Richard W. Zollinger II, M.D.

Crohn's disease is a chronic sclerosing granulomatous disease primarily involving the gastrointestinal tract. Various studies have suggested that environmental factors, genetic predisposition, transmissible viruses, and immunologic sensitivity may play roles in the pathogenesis of this illness. However, despite some interesting inroads, no one clear etiologic factor has been identified as an agent which leads to Crohn's disease. Medical management consists of antibiotics, steroids, and Azulfidine, which appear to offer both symptomatic relief and, in some instances, histologic improvement during the active phase of the disease. Surgical intervention remains a first line of defense for the complications of Crohn's disease including obstruction, hemorrhage, perforation, and intractable disease. It is suggested that a better understanding of the etiologic factors will allow improved medical control of the disease, thereby decreasing the necessity for surgical intervention.

CROHN'S DISEASE IS THE EPONYM for a chronic, sclerosing, granulomatous disease of the gastrointestinal tract first described by Burrill Crohn in 1932. In most patients, the disease is confined to the distal ileum and is identified as terminal ileitis. However, because the disease can affect any or all areas of the alimentary tract, the inclusive term, regional enteritis, often is used. When only the colon is involved, the disease may be called granulomatous colitis. Well-described extra-alimentary tract manifestations of this disease include ankylosing spondylitis, polyarthritis, eczema, and hay fever.¹ The purpose of this paper is to review the disease and its surgical and medical treatment, as well as to discuss epidemiologic and etiologic agents thought to be related.

Symptoms

The patient with Crohn's disease often describes gradual onset of fatigue, weight loss, diarrhea, and abdominal discomfort

that increases after eating. The diarrhea rarely is associated with bleeding. However, onset of symptoms can be acute and can mimic acute appendicitis. When this occurs, patients may complain of right lower quadrant pain, low grade fever, nausea and vomiting, and the diagnosis often is made at the time of operation.¹

Pathology

Peritoneal surface of segments of intestine affected by Crohn's disease are identified readily, appearing red, thickened, and covered with gray exudate. A characteristic feature is the presence of "creeping fat" which may encircle involved segments. The mesentery is thickened and rubbery. On palpation, the lumen is narrowed due to transmural thickening. Diseased segments of the bowel often adhere to one another and form fistulas, but others may be separated by areas of normal appearing bowel called "skip" areas.

When the involved bowel is opened, the mural changes observed depend upon the stage of the disease. In the early phases there is significant edema of the bowel wall, particularly in the submucosa. In the later stages the submucosa becomes densely fibrotic with mucosal "rake ulcers" that lead to possible fistula formation.

Dr. Coccia, Columbus, Medical Student, The Ohio State University College of Medicine.

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Gross pathologic changes are confirmed easily under the microscope. In the early phase, the mucosa is normal except for an increase in goblet cells. In the intermediate stage, lymphocytes, plasma cells, and eosinophils are present in the lamina propria with significant edema underlying the submucosa. Granulomas are seen in the submucosa as well, and consist of histiocytes that coalesce to form Langerhans-type giant cells and noncaseating epithelioid cell granulomas. In the late phase, the mucosa is totally destroyed, villi are absent, and glands are atrophied.^{1,2}

Epidemiology

The incidence of Crohn's disease is increased in Northern Europeans and Anglo-Saxons, while it is low in Orientals, Blacks, and American Indians. It is interesting that although Crohn's disease is rare in Israelis, it is quite common in Jewish descendants who live outside the native state.^{3,4} There is no apparent explanation for this difference.

Crohn's disease occurs with equal frequency in men and women, and in most cases is manifested before the age of 40. The peak times of symptom exacerbation appear to be the cold winter and hot summer months.^{2,4} No explanation has been given for these seasonal occurrences.

Familial aggregates of the disease have been well described. Immediate relatives of a patient with Crohn's disease are more likely than other people to develop inflammatory bowel disease (IBD), whereas the more distant the relatives of an index case, the less likely they are to develop IBD.²

Etiology

Several investigators have attempted to ascribe the cause of Crohn's disease to the effects of diet, soil, air, and even water. One study demonstrated that people who eat large quantities of sweets are more likely to develop regional enteritis,⁵ while on the other hand, another study showed that the disease is not common among Israelis who eat great quantities of sweets.⁶ These and other studies clearly demonstrate that the influence of environmental factors in the occurrence of Crohn's disease remains controversial.

Some progress has been made toward establishing a genetic basis for Crohn's. It is known that patients with Crohn's often have ankylosing spondylitis and that over 90% of patients with ankylosing spondylitis have the genetic marker HLA B27 in their chromosomal structure.² Morris, et al,⁷ showed that patients with IBD and ankylosing spondylitis had a high incidence of HLA B27. On the contrary, patients with IBD and peripheral arthropathy (not ankylosing spondylitis) are HLA B27-negative. Thus, there appears to be some evidence of a genetic marker in Crohn's, although at this point, data are little more than preliminary.

Other investigators have attempted to secure evidence that Crohn's disease is transmissible. Mitchell and Rees⁸ injected footpads of normal and immunodeficient mice with homogenates of tissue involved with Crohn's disease and controls with specimens obtained from healthy volunteers. In early follow-up, a majority of all mice injected with Crohn's developed granulomas in footpads. However, some in the control group developed granulomas as well. When followed over longer periods of time, those injected with Crohn's homogenates maintained granulomatous formation, while controls lost the ability to form granulomas, indicating the chronicity of the disease. Cave, et al,⁹ duplicated the results of this study, using rabbits. Both studies appear to demonstrate that regional enteritis is a slowly evolving, chronic, transmissible disease.

The suggestion that Crohn's may be in part transmissible has led investigators to search for a specific agent, possibly a virus. Many new viral isolation techniques have become avail-

able recently to aid these studies. Aronson¹⁰ now uses a modification of the cocultivation technique described in detail in his articles. Tissues from all parts of the gastrointestinal tract first were obtained from patients with (1) regional enteritis, (2) other gastrointestinal problems (controls). The tissues were biopsied multiple times, then isolated in cell cultures using human embryonic lung and observed for cytopathic effect. Viruses were obtained from 16 of 24 patients with Crohn's disease; however, 14 of 20 patients with other gastrointestinal problems had positive viral cultures as well. Of those with no gastrointestinal symptoms, only one yielded positive viral cultures. In addition, three patients with Crohn's disease had positive isolates in their regional lymph nodes. That Crohn's disease may be virally induced formed the basis for the next stage of this experiment — identifying the agent.

The isolates from these tissue cultures were termed "Vermont isolates." The viruses are approximately 50nm in size, determined by milipore filtration. Since growth is not inhibited by 5-iodo-2-deoxyuridine, an RNA virus is suspected. The virus is further characterized as ether-stable, acid-stable, and heat-stable. These are all characteristics resembling picornaviruses.^{10,11} Thus, even though the exact nature of the viral agent is not known, the above characteristics indicate that the Crohn's virus is the same as or very similar to a picornavirus.

On the basis of these data, the investigator concludes that the patients with Crohn's disease have a higher degree of RNA-type viruses in the diseased segments than do controls. Since the virus can be retrieved from patients with other gastrointestinal problems, a definite causative relationship between the virus and Crohn's disease is not shown. This experiment, in combination with the experiments of Mitchell and Rees and Cave and Kane, give credence to the viral etiology of Crohn's. However, it is obvious that the responsible virus requires further definition. Furthermore, and most important, the specificity of the so-called Vermont isolates as causative agents of Crohn's disease must be proved.

The investigator also noted the positive isolates obtained from the regional lymph nodes of three patients with Crohn's. He therefore stated that this could be a crucial point when considering surgical resection for Crohn's, and that perhaps lymph nodes need to be resected in order to prevent recurrent disease. Obviously positive isolates from the lymph nodes of three Crohn's patients is not sufficiently substantial evidence to warrant surgical resection of nodes in these patients. This point needs to be investigated further.

Finally, consideration of the etiology of Crohn's disease must include possible immunologic factors. Several studies have demonstrated that immune complexes are present in the serum of patients with regional enteritis. Upon examination, the affected intestinal wall contains fibrin, IgG, and complement, all of which indicate deposition of immune complexes. In addition, the extent of gastrointestinal involvement correlates with the level of serum complexes, while there is no correlation between the level of complexes and the severity of extraintestinal manifestations. Furthermore, since complexes utilize complement, one would expect that serum complement levels would be decreased. This is not the case. Rather, patients with regional enteritis show an increase in serum complement levels. Thus, data concerning the contribution of immune complexes to Crohn's disease are contradictory. Once again, further investigation is needed.¹²

Evidence that lymphocytes are etiologic factors in IBD is somewhat more impressive.¹² T-lymphocytes sensitized to antigens have been found in the involved bowel of Crohn's patients. These lymphocytes are known to stimulate migration-inhibition factor, migration-activating factor, and lymphotoxin, and may cause the gross and microscopic changes seen in Crohn's disease.

Some evidence exists that K cells, which are of T cell lineage,

may be responsible for cytotoxicity. K cells react with the Fc component of antigen-antibody complexes; these cells can be activated in vitro by the IgM fraction of serum of patients with Crohn's disease, setting up a cytotoxin cascade. However, K cells have not been seen in the intestinal wall of Crohn's patients, so their contribution as etiologic agents is at best speculative.^{3,12}

Most investigators suggest immunologic mechanisms in Crohn's disease, particularly a lymphocyte-mediated reaction, but results are preliminary and not conclusive.

Therapy

Medical treatment traditionally consists of improved nutrition and various pharmaceuticals including steroids, antibiotics, and azothioprine. Azothioprine, a derivative of 6-mercaptopurine, is an immunosuppressant that acts by inhibiting de novo nucleic acid biosynthesis. However, asymptomatic response to this form of therapy is inconsistent. As a result, it is little used today.³

Azulfidine (sulfasalazine) has been used for many years as a symptomatic treatment for Crohn's disease. The mechanism of action is unknown, but the drug is effective only when given orally. It is known that colonic bacteria break the drug into two components: salicylates and sulfapyridine. Since salicylate is excreted unchanged in the stool, sulfapyridine, which is absorbed, may be the molecule responsible for clinical improvement. However, it is well known that salicylates inhibit prostaglandin synthesis and thus may be acting as a local anti-inflammatory agent.¹³ Consequently, it has not been conclusively shown which component is responsible for improvement.

Flagyl is being used in the medical treatment of regional enteritis, particularly in the presence of associated enterocutaneous fistulas. The specific mechanism is unknown; but like many other drugs, it offers symptomatic relief.

At present, steroids provide the best medical therapy for patients with Crohn's disease. The drug appears to act by relieving symptoms of diarrhea, abdominal discomfort, and fever, and also effects mood elevation in these patients. It appears to prevent obstructive symptoms because of its anti-inflammatory action that reduces bowel edema.¹ However, the exact mechanism of action has not been conclusively proved.¹³

All the drugs listed are immunosuppressants. However, there is abundant evidence that patients with Crohn's disease are immunodeficient. Therefore, drugs that stimulate the immune response must be considered. In fact, agents such as BCG, levamisole, and transfer factor have been given for this specific purpose. Unfortunately, no data that evaluate the effect of BCG and levamisole are available. However, positive clinical results have been obtained from the use of transfer factors.¹²

Despite medical management, up to 90% of patients ultimately require surgical intervention.¹⁴ The basic surgical precept is to operate only when there is a surgical emergency. Indications for surgical intervention are obstruction, hemorrhage, pain, perforation, and intractability. Some elective operations are performed; for example, when stunted growth in children results from medical management.¹³

The goal in surgical intervention is to resect as little bowel as possible and to remove only gross disease. Surgery remains palliative, owing to the fact that recurrence is quite high.

Many epidemiologic and etiologic factors of Crohn's disease have been investigated. The only certain fact is that there is no single known cause. It may be that many factors are required to induce the disease in patients. In light of this, perhaps researchers should place greater emphasis on the interaction of various causative factors rather than the examination of one isolated fact at a time.

The management of patients with Crohn's disease is as confusing as the etiology of the disease itself. However, it is well established that medical management works and is used first and foremost, while surgery is reserved for emergencies. Perhaps a better understanding of the etiology of this mysterious disease will lead to its more effective control and eventual prevention, which is the ultimate goal of all medical treatment.

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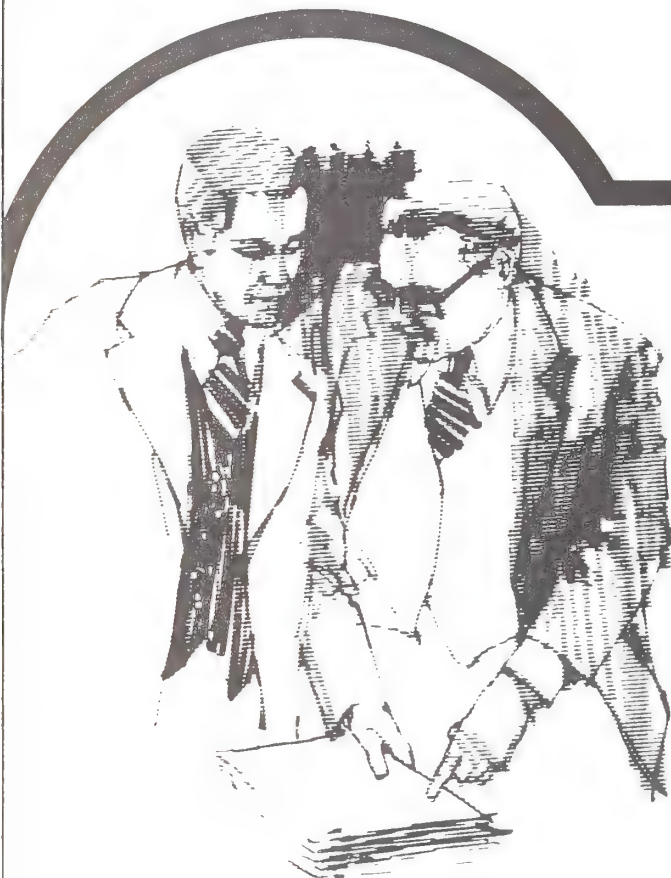
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Council Proceedings

continued

Auditing and Appropriations for study and report back to the Council.

Physicians Administrative

Corporation of Ohio (PACO) — Dr.

Abromowitz presented a report on Physicians Administration Corporation of Ohio and indicated that a detailed report will be presented in December.

Financial and Membership Department

The report of the Department was presented in writing for information of the Council.

Membership Statistics — Mrs. Wisse presented membership statistics.

The Council authorized the Membership Department to bill those physicians moving out of the state for renewal of membership on a non-resident basis.

Treasurer's Report — Dr. Barr presented the report of the Treasurer and it was accepted.

OSMA Pension Plan — The minutes of a September 21, 1982 meeting of the Trustees of the OSMA Pension Plan were accepted and filed.

Employees Benefits Committee — The minutes of the Employees Benefits Committee meeting of September 21, 1982 were accepted and filed.

Department of Education & Meeting Management

The Department report was presented in writing and was filed.

Committee on Education — The minutes of the October 16, 1982 meeting of the Committee on Education were presented by Mrs. Dodson and **were approved** and filed.

Committee on Emergency & Disaster Medical Care — Mr. Torrens presented the minutes of the September 22, 1982 meeting of the Committee on

Emergency & Disaster Medical Care. The minutes were filed.

Department of Government Relations

The written report of the Department of Government Relations was presented by Mr. Gillen and was filed.

Ohio Voluntary Effort — Mr. Gillen discussed the Ohio Voluntary Effort. His report was accepted for information.

Department of Organizational Services

Mr. Campbell presented the written report of the Department and it was filed.

AMA Delegation — Drs. Lewis and Clarke presented reports on AMA issues and activities.

ERISA Trusts — The Council discussed the concept of a self-funded ERISA Trust to provide for payment of members' health care costs.

The Council authorized continued investigation of the concept.

Department of Health Education

The written Department report was presented by Mr. Clinger and it was filed.

Joint Advisory Committee on Sports Medicine — The minutes of the Subcommittee on Legislation and Policies and Guidelines of the Joint Advisory Committee (September 17, 1982), were presented by Mr. Clinger and were filed.

The minutes of the Subcommittee on Education of the Joint Advisory Committee (October 31, 1982), were presented by Mr. Clinger and were filed.

Committee on Impaired Physicians — Dr. Ayres presented the October 10,

1982 minutes of the Committee on Impaired Physicians.

Dr. Ayres commended Bob Clinger for the quality of his work with the program at the staff level.

Amendments to the general principles of the program **were approved**; including additions to Options I, II and III.

The Council received a recommendation and voted to study the feasibility of establishing a loan fund for the assistance of impoverished, impaired physicians involved in impaired physicians' programs.

The proposal was referred by the President to the Auditing and Appropriations Committee.

A request from the Committee for legal opinion on records was referred to staff Counsel.

The report as a whole was accepted.

The Council expressed its appreciation to Dr. Ayres for his personal contributions to the success of the program.

Department of State & Federal Legislation

State Legislation — Mr. Burkland and Dr. Clarke discussed the status of foreign medical graduate licensing.

The Committee, established under H.B. 694 original budget document, to consider Medicaid problems has met several times and will hear from OSMA and specialty societies soon, according to Mr. Burkland.

The Hospital Licensure Bill was discussed by Messrs. Burkland and Bateson.

Department of Insurance Rule on Capitalization of IPA and HMO Programs

Ms. Costello discussed the proposed rule of the Department of Insurance requiring a million dollar reserve for HMO programs.

The Council **voted to support** the HMO and IPA positions against the rule.

continued on next page

Council Proceedings

continued

Federal Legislation — Mr. Mulgrew reported on Federal Legislation.

Department of Communications

Ms. Doll presented the report of the Department of Communications.

Department of Marketing & Field Service

Mr. Holcomb presented the report of the Department of Marketing and Field Service.

Task Force on Marketing and Competition

— The minutes of the October 21, 1982 meeting of the Task Force on Marketing and Competition were presented by Mr. Holcomb and were filed.

Legal Counsel Report

The Council **voted to proceed** with legal action relating to the Advance Plan marketed by Ohio Medical Indemnity Mutual, Inc., by authorizing the filing of a lawsuit challenging the prohibition against assignments involving physicians who do not sign the "participating agreement."

Ohio Department of Health

Ohio Director of Health, Dr. John Ackerman, presented a report for the information of the Council.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

Uncompromising patients

Health care is one area in which Americans are unwilling to sacrifice even when faced with economic hardship. They may not buy a car, or a new refrigerator this year, and people are tightening their belts when it comes to their food budgets. But when it comes to their health care needs, few people are willing to compromise.

John C. Bedrosin
Executive Vice President
National Medical Systems

But what have you done for me lately?

*Editor's Note: You belong . . . you're a member of the OSMA . . . but sometimes you wonder why. You pay your dues, and you get your **Journals**, but what else do you get in return? "What," you can't help thinking, "has the OSMA done for me lately?" With this new column, the **Journal** hopes to bring to your attention those reasons for being a member . . . the ongoing services provided by the Association, as well as its most recent accomplishments. If you've been wondering what the OSMA has done for you lately, read on . . .*

OSMA was instrumental in getting the Ohio Public Health Council to rescind Ohio's Certificate of Need Rule which required health planning approval for certain computed tomographic scanners (CAT scans). An OSMA-sponsored amendment in Senate Bill 4 resulted in Ohio licensed physicians, partnerships and professional associations comprised of a single physician or group of physicians being exempt from having to be licensed as a terminal distributor of dangerous drugs and paying the \$50 licensure fee.

OSMA provides an Ombudsman Service which assists physicians with third-party payment problems. Call 228-6971.

OSMA publishes several pamphlets and brochures which help to educate your patients about healthy lifestyles and how to take better care of themselves.

OSMA conducts a speaker's bureau. Speakers are available to attend your county society meetings and discuss topics such as legislation, communications, marketing and competition in health care and other current topics.

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Board certified anesthesiologist for part-time and emergency back-up in our expanding surgical services. We are a 68-bed JCAH-accredited community hospital located in North Central Ohio. Please send current detailed CV to: Patricia A. Bone, Director Human Resources, The Bellevue Hospital, Bellevue, Ohio 44811.

ANESTHESIOLOGIST — Board certified or eligible; 200-bed community hospital, Northwestern Ohio. Most major surgeries. Contact: Jack M. Bryan, Associate Administrator, Memorial Hospital of Sandusky County, 715 S. Taft Avenue, Fremont, Ohio 43420, 419-332-7321.

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Emergency Positions - available with emergency physician group in PA, NY, NJ, VA, WVA, MD, KY, FL, and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to: NEEMA Emergency Medical, Suite 400, 399 Market Street, Philadelphia, PA 19106 or phone 215-925-3511 in PA, or 800-523-0776 outside PA.

The OSMA and the AMA will cosponsor "Gearing Up for Retirement," March 18, 1983 at the Marriott Inn North, Columbus, Ohio. The program will inform physicians and their spouses of the considerations in planning for retirement and closing a medical practice due to retirement or death.

OB/GYN — Board eligible or Board certified — to join busy solo practitioner in small Florida town; growing business with possible partnership; located in popular lake/fishing recreational area near the Gulf. Send complete resume to Box 973, The Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

PATHOLOGIST — 40 hours per week — \$19,500 per year — to perform autopsies, to examine and prepare reports on tissues of surgical patients. To examine cells for pathology and related tasks — teaching, research, etc. Degrees required: Public Health and M.D. Send resumes to the Ohio Bureau of Employment Services, 3135 Euclid Avenue, Cleveland, Ohio 44115. Attn: Mildred McGill, Identification No. 0221264.

RESIDENT IN FAMILY PRACTICE WANTED for diagnosis, treatment and patient care in all areas of family medicine. Requires 6 years college including M.D. degree. 50 hours per week, \$17,200 per year. Contact Mr. Silas Willhite, OHIO JOB SERVICE WEST, 3394 North Blvd., Columbus, Ohio 43204. Reference Number: No. OH14408.

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Clinical Notes (continued)

expectations, however, the authors found essentially no difference between the two in treating all three categories of phobia. It was not that patients did poorly with behavior therapy, but that they did unexpectedly well with supportive psychotherapy.

In this sense, there is specificity to psychotherapy in that the therapy leads to the correct in vivo beneficial activity. This hypothesis gives a theoretic background to the question of whether there is psychotherapy toxicity. At least for the treatment of phobic patients, any therapy that interferes with patients confronting phobic situations may well be toxic. — *Archives of General Psychiatry* Volume 40, Number 2, February, 1983 pgs. 139-145

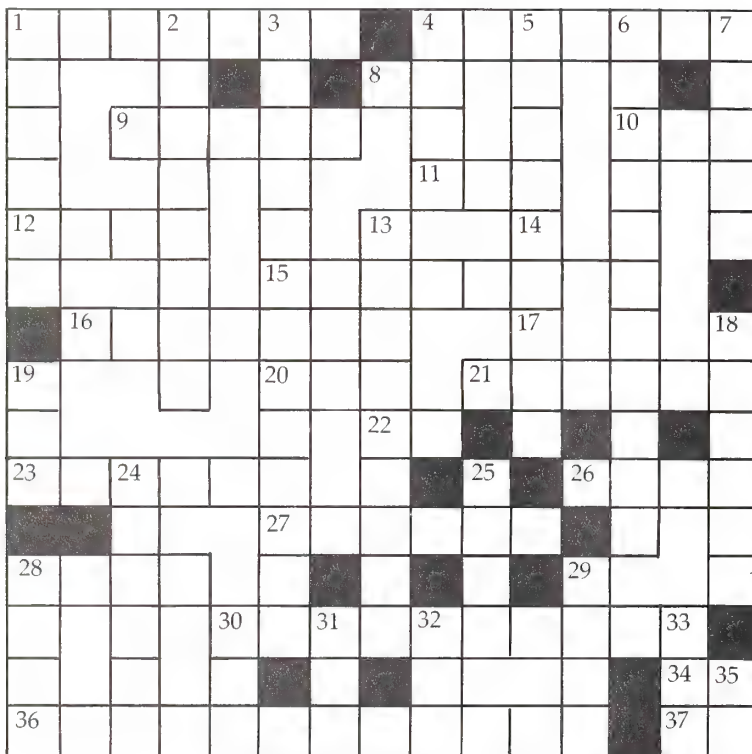
Medical Crossword

By R. M. Benson, M.D.

DI GEORGE SYNDROME

ACROSS: 1. Thoracic organ often affected by DS, 4. Thymic tissue in DS, 8. Partner of DC, 9. Greek marketplace, 10. Fish eggs, 11. Rowing implement, 12. Too, 14. Spot, 15. Recoil, 16. Blood phosphorus in DS, 20. Able, 21. Pharyngeal pouch underdeveloped in DS, 22. Major etiology for Addison's disease in early twentieth century, 23. Lymphocytes influenced by thymus gland, 26. Cinema, 27. Skin picture, 28. Optic organs, 30. Underdevelopment, 34. Negative reply, 36. Chin problem in DS, 37. Accomplish.

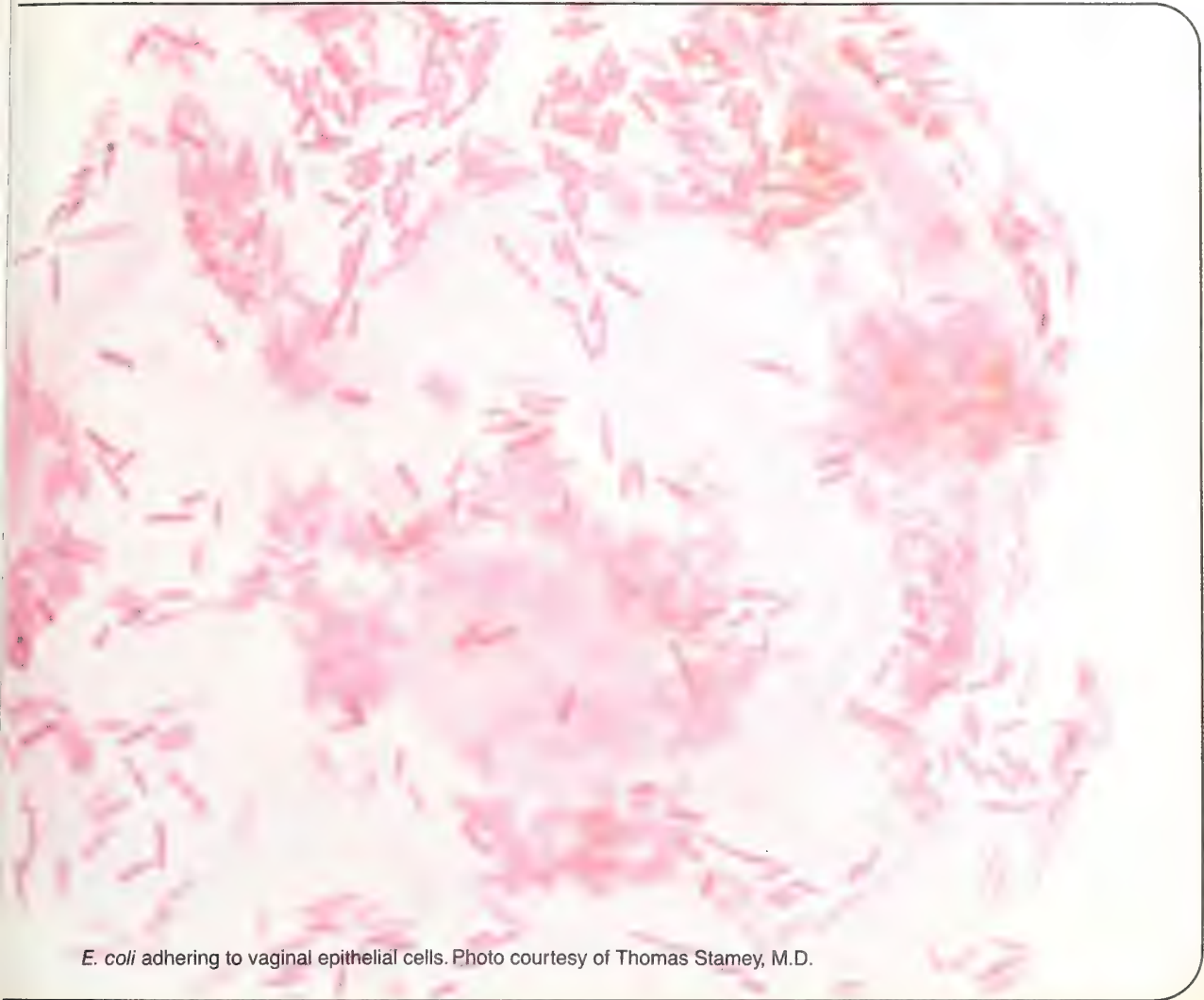
DOWN: 1. Nasal atresia sometimes seen in DS, 2. Syndrome of underdevelopment of third and fourth pharyngeal pouches, 3. C-V arch lesions in DS, 4. Reverberation, 5. See 21 across, 6. Calcium regulating endocrine organ deficiency in DS, 7. Palate or lip defect in DS, 13. Deletions have been noted on this chromosome in DS, 17. Blood calcium level in DS, 18. Pharyngeal pouch derivative underdeveloped in DS, 19. Consume, 20. Expensive, 24. Agent inducing vomiting, 25. Furuncle, 28. Test, 29. West Point (abbr), 30. Prepaid health care system, 31. Pot and ———, 32. Fruit seed, 33. Also, 35. Scoreless.



(Solution is on page 209)

Dr. Benson is the Director of Pediatric Endocrinology at Children's Hospital Medical Center, Akron.

cling to receptors



E. coli adhering to vaginal epithelial cells. Photo courtesy of Thomas Stamey, M.D.

The pharmacologic and pharmacokinetic activities of Bactrim (trimethoprim and sulfamethoxazole/Roche) make it particularly appropriate for the treatment of recurrent urinary infections.* The vast majority of *E. coli* strains and a wide spectrum of other common uropathogens are susceptible to Bactrim *in vitro*.⁴ Bactrim achieves high concentrations in the urine, and the trimethoprim component diffuses into the vaginal area and attacks susceptible uropathogens that cling to mucosal cells.⁵ In the fecal flora, Bactrim suppresses Enterobacteriaceae,⁶ with little resulting emergence of resistant organisms. Bactrim is contraindicated in pregnancy at term, nursing mothers, infants under two months of age and documented megaloblastic anemia due to folate deficiency.

Bactrim DS. Twice a day for 10 to 14 days in recurrent urinary tract infections.*

* Due to susceptible organisms such as *E. coli*, *Klebsiella-Enterobacter* and *Proteus* species.

Bactrim™ DS

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See next page for references and a summary of product information.

References: 1. Källenius G et al: *Lancet* 2:604-606, Sep 19, 1981. 2. Lomberg H et al: *Lancet* 1:551-552, Mar 7, 1981. 3. Schaeffer AJ et al: *N Engl J Med* 304:1062-1066, Apr 30, 1981. 4. BacData Medical Information Systems: *Antibiotic Sensitivity Report*, Winter Series, 1981. 5. Stamey TA, Condy M: *J Infect Dis* 131:261-266, Mar 1975. 6. Rubin RH, Swartz MN: *N Engl J Med* 303:426-431, Aug 21, 1980.

Bactrim[®] DS

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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections. For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL

PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects. Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients, cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 14 days.

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PRESIDENTIAL PERSPECTIVES

The Message in the Graffiti

By C. Douglass Ford, M.D.



C. Douglass Ford, M.D.

I am old enough to remember some things about the great depression. To help identify which economic depression one is writing about, the one in the thirties was always called "the great depression." I wasn't conversant then with the economic and political issues of that day. My brother Bob and I never went hungry. We were not lacking the creature comforts of clothing and shelter. There were few frills, though. There was a near mandatory frugality in the family that was typical of many families of that period.

I can remember parental admonishments to leave a clean plate or to take care of belongings so that they would last (Bob's flexible flyer was just passed on to his grandson). I also remember my parents provided food to the occasional itinerant who requested help. Usually, but not always, that hungry man would accomplish some chore in exchange for the food.

Not infrequently, I would notice some strange and, to me, meaningless marks that had appeared on the sidewalk or curb in front of our house, there in Philadelphia. Later — much later — I learned that the men my mother fed would mark these walls with a code which would inform

others of their genre that "food was available here."

The idea that one had some responsibility to help those who were "down on their luck" was taught to us by example. The folks were never very talkative about their compassion for these unfortunates. They were not unusual either. Many families gave food to strangers who were in need. Some even provided shelter.

Last January, I wrote to each County Society and Specialty Society President about meeting the needs of our new class of medically indigent people in Ohio. These are the people who have lost their family income due to unemployment, who have lost their health insurance benefits (should that not be called "sickness insurance"), and who are ineligible for existing programs such as Medicaid or county welfare.

To date (March) I want to point with admiration to Dr. Ray Gifford, President of the Cleveland and Cuyahoga County Academy of Medicine; to Dr. James Barnes, President, Columbus and Franklin County Academy of Medicine; and to the Montgomery, Pickaway and Medina County Academies of Medicine. All of these counties have involved their members in a program

for the care of their unemployed neighbors. Their programs vary in scope and complexity depending upon the available resources in each of their respective counties. I know that Richland and Lucas Counties are contemplating ventures with a similar purpose. There may be other county societies of which I am unaware, that are developing programs tailored to their particular needs and resources.

Throughout the United States, There are 30 or more community programs now in existence which are geared to meet this need. More are appearing every day, according to the AMA. I am proud that Ohio's societies are involved in this growing movement. I admire my colleagues who are willing to participate in these plans to care for the "new indigents." Those families are our neighbors who once were productive members of our communities and who will again be such. They, too, are down on their luck.

If you look closely, you may see some curious marks on the sidewalk in front of the House of Medicine. I believe they represent the code which says to our needy friends, "Medical care is available here."

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An Open Letter to Physicians with Physical Impairment

For the past two years, we have been involved in compiling a resource directory for physicians with physical impairment. The work is funded by a grant from the St. Paul-Ramsey Hospital Medical Education and Research Foundation. The purpose is to list physicians with various physical disabilities who are willing to provide information and referral services to physicians who incur the same disability and need specific information. Existing rehabilitation programs simply are not equipped to deal with the situation and "impaired physician" services, except for the recently formed "American Society of Handicapped Physicians," are directed almost exclusively to those physicians with mental illness or drug dependency.

The biggest problem has been poor participation. It currently is estimated that 4% of all physicians are not in active practice because of a physically disabling condition, and that 25% of the physicians have the potential to be rehabilitated into the active practice of medicine. In real numbers, this constitutes 1% of the licensed physicians in this country, or 4,500 physicians. Our goal is to identify these physicians and encourage their participation. To date, we have placed advertisements in over 100 major medical journals and have had response from less than 200 physicians. In retrospect, it appears this was due to the use of inappropriate terminology in the ads. Physical disability does not imply inability. Our use of the term "handicapped physician" was inappropriate since the majority of physically disabled physicians are not handicapped in their practice of medicine. We apologize for the inappropriate terminology and again ask that all physicians, active or inactive, with any type of physical disability, contact Dr. Zondlo, St. Paul-Ramsey Hospital Medical and Educational Research Foundation, 640 Jackson St., St. Paul, MN. 55101. The directory will be completed in six to eight months and at that time it will be sent to only those physicians who are listed therein. Upon receipt of your initial response, information forms will be mailed. All correspondence is confidential.

All physicians with physical disability, no matter how small, are encouraged to respond. Information from a doctor with even a minor disability may be of value to another doctor with multiple disabilities. The cornerstone of this project is your participation.

—Frank Zondlo, M.D.

(paid advertisement)



SECOND OPINION

Abuse in UCR

A Financial Bonanza for Physicians

By Leonard B. Greentree, M.D.

It is proposed that a Select Ad Hoc Committee, including peer review, be speedily convened by our federal government in Washington to restructure Health Care in this nation, whereby this can be dispensed with the greatest cost effectiveness to all concerned.

Today, many doctors, particularly surgeons, are making great fortunes at the expense of the American public, and this cannot be denied! This financial bonanza to the medical profession is factually derived from tax dollars and costly insurance premiums generated from the general public to its detriment. All this began at the time when the principal source of income to the medical profession shifted from the modest means of the average patient to that of the impersonal bureaucracy in the third party insurance industry. This permits exorbitant doctor fees to be considered as being the "usual, customary, and reasonable fees" (UCR) of these particular physicians, as effectively advocated by the American Medical Association years ago; and to that of seemingly limitless tax dollars appropriated by the federal government to provide proper health care to the young, old and the

indigent in this country. Here, the government's payment of doctor bills, through its worthy **Medicaid** and **Medicare** programs, tends to simulate that of the third party insurance carriers who pay UCR, however costly, when submitted by ever-increasing numbers of business-oriented physicians.

The profit goal in the practice of medicine, rather than that of service to human needs, appears to be the rule rather than the exception to increasingly visible segments of the medical profession, and this goal is causing great hardship to those who are seriously ill, particularly during this period of recession. Along this line of thought, Arnold S. Relman, M.D., editor of the *New England Journal of Medicine* and professor of medicine at the Harvard Medical School, says: "Physicians who see themselves as businessmen (entrepreneurial) argue that profit motive is as American as the Sugar Bowl and without it waste and inefficiency prevail." (*Internal Medical News*, 15: 1 & 33, 1982). This reflects these entrepreneurial doctors' strong belief in their making great wealth from health care at the expense of the general public whenever they can.

All this is a far cry from the early 1930s, when I first received my M.D. degree. At that time, American physicians long enjoyed a special place in the public eye. This respect had been generated not so much by their scientific achievements as by their service to human needs — a devotion to those other than themselves. Traditionally doctors, like the clergy, were considered to be members of the "learned profession," responsible for fulfilling the physical, emotional and spiritual needs of the general public. History can be proud of their efforts. These members of the so-called "learned profession" were somehow expected to live in a modest fashion; to send mostly their sons to the university, in the hope that they too would become members of the "learned profession," and provide service to human needs. Public service without thought of financial gain is still the rule for most clergy in the United States, and our country is indeed proud of these dedicated servants of the Lord.

On the other side of the coin, it is a sad reflection of our times that far too many American physicians seek to live in the life style of the very rich at the expense of the general public, as they

continued on page 317



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ANDREW DI BARTOLOMEO, M.D., Akron, was appointed chairman of the Ohio Emergency Medical Services Advisory Council. Dr. DiBartolomeo is assistant director of emergency medicine at Akron City Hospital.

D. JAMES HICKSON, M.D., Mt. Gilead, was elected to the board of trustees of Peer Review Systems.

S. AMJAD HUSSAIN, M.D., Toledo, was selected to serve on a panel that will advise the government of Pakistan on its five-year health plan. Among topics to be studied by the panel are the relationship of various systems of medicine, ways to increase participation of the private sector in health care, and financial planning for health care. Dr. Hussain is president of the Association of Pakistani Physicians of North America.

The following were elected officers of the medical staff of St. Rita's Medical Center in Lima: **KIRBY V. ANDERSON, M.D.**, chief of staff-elect; **WILLIAM P. LAUF, M.D.**, chief of staff; and **JAMES E. BAGENSTOSE, M.D.**, secretary-treasurer.

Officers elected to serve the medical staff of Ohio Valley Hospital, Steubenville, are: **JOSEPH J. AGRESTA, M.D.**, president; **J. J. MACEDONIA, M.D.**, secretary-treasurer; and **DOMINIC N. FERRERA, M.D.**, president-elect.

WILLIAM H. BUNN, M.D., Youngstown, is the new regional vice president and chairman of the North Central Region Heart Committee. Dr. Bunn is chairman of the department of medicine at Youngstown Hospital Association, and professor of medicine and chairman of the department of medicine at the Northeastern Ohio Universities College of Medicine.

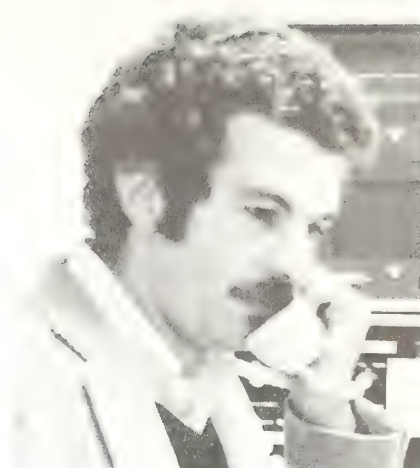
M. J. CASALE, M.D., Warren, was reelected president of the St. Joseph Hospital medical staff. Dr. Casale specializes in obstetrics and gynecology. **WILLIAM S. OWEN, M.D.**, neurosurgeon, was elected vice-president, and **EDWARD C. WALKER, radiologist**, was elected secretary-treasurer.

The following were awarded plaques for 25 years of service at Marymount Hospital:

RAYMOND KLIKA, M.D., ophthalmologist; **SELIG STRASSMAN, M.D.**, pediatrician; **MARIE PANCNER, M.D.**, internist; and **MAXWELL UDELF, M.D.**, ophthalmologist.

PAUL J. MAHAR, JR., ophthalmologist, was elected president of the Mahoning County Medical Society. Serving with Dr. Mahar are **GLENN J. BAUMBLATT, M.D.**, vice-president, and **H. S. WANG, M.D.**, secretary.

The new officers of the board of the Ohio Medical Political Action Committee are: **A. BURTON PAYNE, M.D.**, Ironton, Chairman; **JEROME KIMMELMAN, M.D.**, Toledo, Vice-Chairman; and **JOHN E. ALBERS, M.D.**, Cincinnati, Secretary.



Andrew Di Bartolomeo, M.D., Akron . . . new Chairman, Ohio Emergency Medical Services Advisory Council.



D. James Hickson, M.D., Mt. Gilead . . . trustee member, Peer Review Systems, Inc.



Jack Schreiber, M.D., Canfield . . . Mahoning County's Doctor of the Year.

continued on page 307

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

Competition will increase in 1980s

The following predictions about physicians' practices in the 1980s can be made with a fairly high degree of reliability, if present trends continue:

1. There will be a substantial increase in the number of doctors practicing medicine.
2. In some areas there will be increased competition for patients among doctors offering the same or similar services.
3. In some areas there will be increased competition for patients between doctors and some other types of health care professionals.
4. The percentage of doctors practicing in groups will continue to increase.
5. There likely will be an increase in the number and/or percentage of doctors practicing in salaried positions.
6. There will be an increase in the number of board-certified specialists practicing in rural areas and in smaller towns.

7. Physicians will increasingly experience more complex relationships with hospitals which are built around the interdependence of physician and hospital.

8. In some areas hospital privileges will be harder to obtain and/or will be linked with more specific hospital requirements and expectations of doctors.

9. There will be an increase in the number of physician-controlled facilities competing with hospital facilities.

10. There will be an increasing emphasis on voluntary peer review and utilization review under physician sponsorship at the local level.

11. Physicians' average real income will continue to decline.

Source: "Technique Critique of the GMENAC Report," Center for Health Policy Research AMA, September, 1981.

New breakthroughs in leukemia treatment

A new technique for children's bone marrow transplants and major developments in the use of drugs to combat leukemia in adults were highlights of the Leukemia Society of America's annual research report released during the Society's national annual meeting in Kansas City, Missouri.

Two Leukemia Society researchers, Robert Bast, M.D., and Jerome Ritz, M.D., are members of the team that developed the new bone marrow transplant technique at Sidney Farber Cancer Institute in Boston. The procedure is for children with leukemia who do not have a family member who can donate "healthy" marrow.

The technique involves removing the young patient's own bone marrow, cleaning it of leukemia cells in the laboratory, and then transfusing it back into the child. Drs. Bast and Ritz, along with others, developed the special monoclonal antibodies which target, bind to, and destroy the leukemia cells in the bone marrow.

When the "cleaned" marrow is transfused back into the child, the body sees the cells as its own and

does not reject them. In time, the treated bone marrow begins producing normal, healthy blood components.

Kenneth B. McCredie, M.D., the Society's vice-president for medical and scientific affairs, said the use of drugs in the treatment of leukemia has also resulted in improved survival rates for adults with acute leukemia.



Reports from several institutions indicate significant increases in remission and survival rates as a result of new chemotherapy.

At M.D. Anderson Hospital in

Houston, work done by Society Scholar Michael Keating, M.D., and colleagues, has led to a substantial increase in remission rates for adults with acute myelogenous leukemia, one of the most resistant forms of the disease. Intensive chemotherapy now will induce remission in over 70% of patients.

"Effective chemotherapy for adult victims of acute leukemia has become a reality due directly to the efforts of researchers supported by the Leukemia Society," said Dr. McCredie.

To further improve the outlook for adults with leukemias, researchers are working out sophisticated schedules of various treatments including high dose chemotherapy at the beginning and end of therapy, and central nervous system treatment at the midpoint to eradicate leukemia cells that may have escaped chemotherapy.

Dr. McCredie points out that there is still much work to be done in the treatment of adult leukemias; many patients still relapse after achieving remission. But the hope is that the remissions now being obtained can be extended to an increasing number of cures in the future.

Herpes I & II: The vaccine search continues . . .

Researchers at the University of Cincinnati Medical Center are working on a vaccine against one of the most virulent strains of herpes simplex (herpes I), which causes herpes simplex keratitis, an inflammation of the cornea that is one of the most common severe ocular infections in the country.

The researchers also plan to work on a vaccine against the highly publicized herpes II, which causes genital herpes in sexually active adults and eye infections in babies born to women who have the disease.

The research team is directed by ophthalmologist and cornea specialist Arden Wander, M.D., assistant professor of ophthalmology, and virologist and microbiologist H. Curt Bubel, Ph.D., professor of microbiology. Together they are developing a new concept of herpes simplex virus vaccine that might bestow immunity without the development of the troublesome latent stage of the disease.

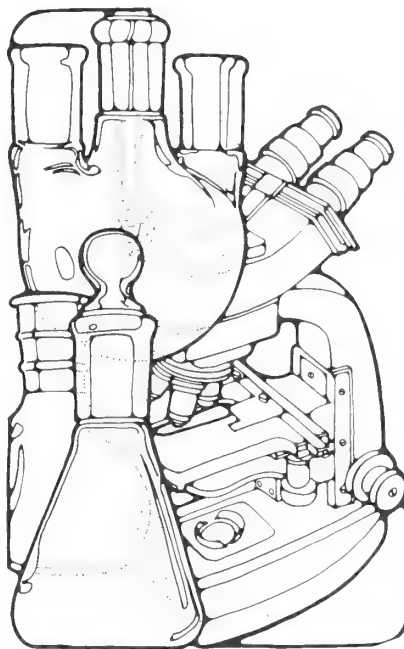
The search for a herpes vaccine has been plagued by the manner in which vaccines were made in the past and by the perplexing latent stage of herpes. To complicate matters more, the ability of the herpes simplex virus to mutate allows it to occur in nature in many different strains.

"The two major types of viral vaccine now available are attenuated (weakened) live virus and killed inactivated virus," Dr. Bubel explains. "Both attenuated and inactivated types of vaccine contain viral DNA. When

effective immune response."

"With herpes," Dr. Wander adds, "one might experience a mild form of infection when the patient is young and healthy, only to have a devastating recurrence when the patient is older or in a more weakened condition."

When it is inactivated, herpes simplex virus sheds its outer protein coat, travels up a pain nerve, and lies



dormant as "naked" DNA in a cluster of nerve cells called ganglia. The virus is undetectable during this latent stage

protein sheath the naked viral DNA seems to go unrecognized and is unaffected by the immune response.

Recently virologists noticed that the first discernible difference between a normal cell and one infected with herpes simplex virus is the formation of early proteins that appear on the outer membrane of the host cell. Dr. Bubel observes that these early proteins form at the onset of herpes infection and are vital to the production of later viral proteins.

Closer study showed that although the early proteins help regulate the manufacture of later proteins, they never become the structural DNA of herpes. It is the later-appearing proteins that act as the actual building blocks of the herpes virus.

Use of a vaccine against the early, regulatory proteins would be "like bombing the automobile factory before the fenders, transmission, engine, and other parts have been assembled to produce the car," Dr. Bubel says.

"The early proteins are just as necessary to the reproduction of the virus and the spread of the disease as the factory is to the production of the automobile," he notes.

A crude vaccine made from these early proteins has shown that it can protect mice from herpes virus-induced skin lesions. Dr. Wander and Dr. Bubel are now testing its effectiveness again against ocular herpes by injecting it into the subconjunctiva of the eyes of guinea pigs, which have an immune system very much like that in humans and show symptoms similar to those seen in human herpes infections.

Although this unique vaccine is still in the earliest stage of development, the finished product may someday be given to children with their regular pediatric vaccines. In the meantime, drugs are used to speed healing and stop the virus DNA from reproducing during the active stage of the attack. The problem is that as the attack subsides, herpes may enter the latent stage and drugs are powerless to prevent recurrence or control the frequency of subsequent attacks.

The search for a herpes vaccine has been plagued by the manner in which vaccines were made in the past and by the perplexing latent stage of herpes. To complicate matters further, the ability of the herpes simplex virus to mutate allows it to occur in nature in many different strains.

live virus vaccine is injected into a person, a mild form of disease develops that stimulates specific immunity. Then, if the same virus is encountered again, the person is protected with an immediate and

except by specialized culture techniques. This is because the immune system must first recognize different surface structures on the foreign body or infected cell before it can counterattack. Without its outer

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References: 1. Traub, Y. M., et al.: Clin. Pharmacol. Ther. 28:765 (Dec.) 1980.
2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. 647 (Suppl.):67, 1981.
3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

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WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS,

EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. **Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings.** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

- Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).
- Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).
- Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).
- Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-99).
- Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTABLE

— Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).



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The 1983

OSMA ART and CULTURE COMMITTEE'S

Photographic Exhibit



"Comrades" by Marvin Aronoff, M.D., Cincinnati

The Ohio State Medical Association's Art and Culture Committee will sponsor a photographic exhibit and competition. The 1983 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1983 Annual Meeting, Columbus, where the entries will be displayed. Winners will not necessarily appear on future Journal covers.

Photographs may be entered in two divisions: Black and White, and Color.

Entries must be in print form (8" x 10" or 11" x 14") in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a \$10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

Name _____

If Nonmember, Spouse's Name _____

Street _____

City _____ State _____

County _____ Zip _____

Telephone _____

Information about photograph:
(provide as much as possible)

Camera _____	Lens _____
Speed _____	Aperture _____
Subject _____	Film Type _____
Date _____	Time of Day _____
Title _____	

Division: ☐ B & W ☐ Color

Processing/Printing: ☐ Professional ☐ Self

Mail or hand carry the photograph, entry form and \$10 entry fee (make checks payable to The Ohio State Medical Association) to: The Ohio State Medical Association Photographic Exhibit, 600 S. High Street, Columbus, Ohio 43215. All entries must be received no later than April 12, 1983.

THE OSMA GROUP PRIMARY PROFESSIONAL LIABILITY INSURANCE PLAN



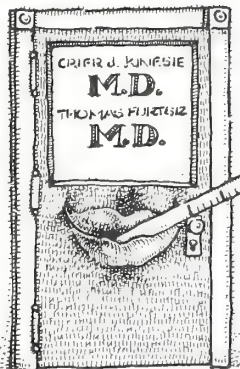
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THOROUGH DAILY CHECK-UP.



Your medical office may appear to be in the best of health financially. Nevertheless, we are prescribing a thorough checkup – daily.

You can administer it yourself, more easily than you can possibly imagine. Just press a few keys on a terminal wired into our computers. You'll learn some very interesting things.

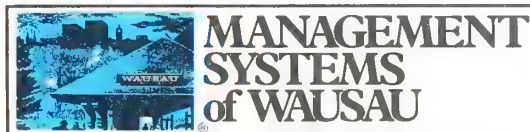
For example, you'll instantly know how efficiently you are operating. What your overhead is. The status of your cash flow. Who is paying and who is owing.

Actually, knowing is one thing, acting is another. Fortunately, Management Systems of Wausau equips you to do both.

Our procedures and systems are tailored to your needs. Is your cash flow hurting? We can move up your billing cycle. Or extend your series of collection notices. Even add the patient's verbal promise to pay to the invoice.

It's likely all this and more can easily be handled by your present staff, trained and supported by us. (We make frequent "housecalls".)

So even if you are already computerized, why not phone us for a second opinion?



1 800 826-0028. We work hard to support you.

In Wisconsin: 1 800 472-0023

But what have you done for me lately?

OSMA recently developed a patient questionnaire which allows you to learn about your patient's level of satisfaction with his or her medical care. Over 12,000 copies have been sold within three weeks.

OSMA conducts a confidential Impaired Physicians Program to help physicians suffering from alcohol, or drug-related problems or mental stress. Assistance may be obtained by telephoning the OSMA offices, 614/228-6971.

OSMA monitors over 100 pieces of health-related legislation each year in an effort to promote and protect the health of all citizens.

OSMA sponsors continuing medical education accreditation programs to insure that CME programs are of the highest quality and that they meet the requirements for relicensure by the State Medical Board.

OSMA publishes patient informational brochures containing standard health information and personalized with your office hours, telephone number, address, and other information about your office which will be helpful to your patients.

OSMA monitors government health agency rules and regulations, testifies before various committees regarding OSMA position, and informs you of changes that will affect your practice of medicine.

BRIEF SUMMARY PROCARDIA® CAPSULES

(nifedipine)

For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: **General:** **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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*"I can do things that I
couldn't do for 3 yrs. including
joining the human race again."*



*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks, taking fewer nitroglycerin tablets, doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

*Procardia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA[®]
(NIFEDIPINE) Capsules 10 mg

Please see PROCARDIA brief summary on adjoining page

Concern for others

WE ARE not among the unemployed but we can imagine what it would be like. We might bite our fingernails as we contemplated how to earn food for this evening's meal. That meal would be of more immediate concern than the next payments on the utilities, the car, the things. We would not get ill, illness would not get us. Medical

insurance due to unemployment, and up to five new patients a month. Charges will be based on the cost of pay, which could be all.

The good doctors

The Cleveland Academy of Medicine deserves a rousing cheer for its offer of free medical care to Cleveland's unemployed victims of the recession. President Dr. Ray Gifford said 100 physicians have already volunteered for the program, and they and their colleagues may treat free as many as 10,000 patients in the future. Many other doctors have continued to treat the program. We've dealt out our share of licks and but in this case our hats are off to them.

Doctors unite to care for jobless

By Alma Kaufman

The Cleveland Academy of Medicine is recruiting doctors and hospitals to provide free health care for laid-off workers and their families in Cuyahoga County. The program, Project '83, was announced yesterday at City Hall by Mayor George V. Voinovich and Dr. Ray W. Gifford Jr., academy president.

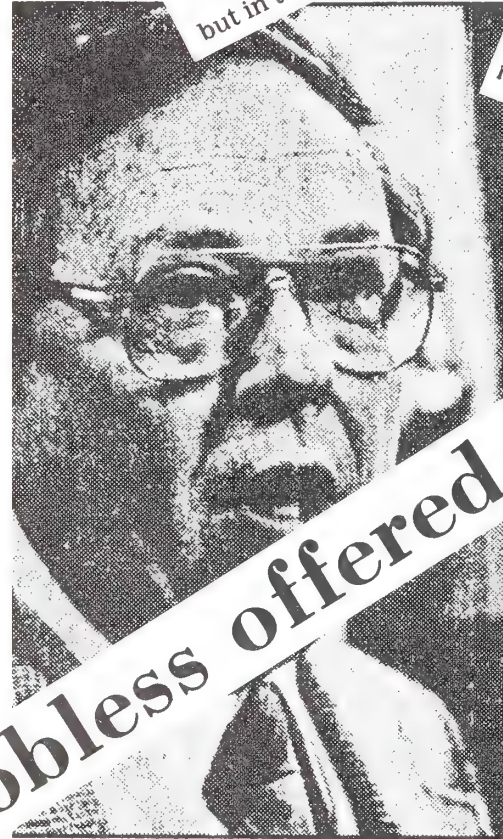
The free care will be available to county residents who lost their jobs after Dec. 31, 1980, and have no health insurance.

Jobless offered free medical care

Physicians to cut price for jobless

By RITA RUBIN

Beginning Thursday, Franklin County physicians and pharmacists will offer their services at reduced prices to unemployed residents who have lost health-care benefits but are ineligible for Medicaid. Dr. James Barnes, president of the Academy of Medicine of Columbus and Franklin County, said the program is aimed at helping people



Dr. Ray Gifford Jr., president of the Cleveland Academy of Medicine, announced the program for the unemployed as Mayor George V. Voinovich listened.

Local Physician Is Trying To Start Medical Program For Unemployed

Recession, depression and unemployment have been making headlines long enough. Recently, the OSMA set out to find what it could do to brighten the picture.

... And Now, for the Good News

By Karen S. Edwards

Employment equals stability. Period. Never before has that statement been as loquacious as it is today. Thousands of Ohio workers are learning that unemployment means more than the devastating loss of income. It also may mean a loss of health care benefits.

That's a serious loss in a system that usually carries such a high price tag that only insurance companies and government agencies have pockets deep enough to make the payments. What does a patient do when he or she no longer has an employer to pick up the bill — and the government won't?

That's the question the Ohio State Medical Association (OSMA) chose to address at the end of last year. Shocked by the State's increasing number of unemployed, uninsured — and those ineligible for Medicaid and other existing assistance programs — C. Douglass Ford, M.D., OSMA President, acting on behalf of the OSMA Council, sent a request to county medical societies, asking them to develop local programs which would provide free or reduced-cost medical care to the new medically indigent.

In his letter, dated December 20, 1982, Dr. Ford wrote:

"Most of the eligible in the proposed program will be those who, until now, have been willing and able to defray the costs of their medical care. These individuals may be deferring needed care because of embarrassment, or for personal financial limitations. It is our profession's responsibility to continue to provide medical care until they can once again absorb these medical costs."

The OSMA suggested that the county programs should:

1. Identify and recruit the volunteer cooperation of physicians, hospitals, and other resources available for the provision of service to the recipients.

2. Establish eligibility requirements for entrance into the program, and a method of identifying those who are eligible.

3. Identify a public agency or group to act as a referral center for the eligible. This might be the County Health Department, the "Community Chest," or some other agency willing and capable of administering the program.

4. Recruit physicians willing to volunteer to participate in the program in as great a number as possible, so that an equitable distribution of the caseload may be achieved.

5. Develop a system of compiling the types and members of the professional services donated under the auspices of the program. If desired, the monetary equivalent of these services can be tabulated.

6. Publicize the availability of the plan to the county's target population so that the "newly medical indigent" will be able to participate, once the program is in place.

Response from the counties has, for the most part, been enthusiastic.

Some, like Scioto County, feel that adequate assistance already is being provided locally, so a special program developed by the county medical society is unnecessary. Others, like Cincinnati's Academy of Medicine, prefer to wait until they see a "demonstrated need" before becoming involved in a full-scale program.

"We would have to consider whether or not the already existing sources of medical care can accommodate the needs of the unemployed," said William Galligan, Executive Director of the Cincinnati Academy, in an article in the January 30th *Cincinnati Enquirer*. Galligan went on to describe Cincinnati as one of those rare northern cities which has a widespread public health

continued on page 255

Columbus' Special Concern

Projects and programs often look good on paper, but how do they function once that first telephone begins to ring?

As far as the Academy of Medicine of Columbus and Franklin County is concerned, their "Project Health Concern" is doing quite well — and they already have over 300 phone calls to prove it.

"The Columbus Academy has had some very positive feedback on their project, both in the media, and in the community," says Rebecca J. Doll, Director of Communications for the Ohio State Medical Association (OSMA).

Both the morning and evening papers have carried stories of the project, and complimentary editorials have followed:

"Project Health Care is a splendid example of the way local folks are responding to the plight of their less fortunate neighbors during these lingering hard times," says one

editorial.

The broadcast media have been just as attentive and just as favorable. They were there when the project was first announced, then again a couple of days later to do a follow-up story.

The community has, likewise, taken the project to heart.

"The first day after we announced the project, we had the Junior League of Columbus ask us if we needed volunteers to help staff the phones," says Ann Clinger, Administrative Assistant at the Academy of Medicine, who is coordinating the project.

Since then, other offers of help have come in from the community. Some, like the Junior League, have volunteered to answer calls regarding the project — enabling the Academy to have two persons, a full-time staff member and a volunteer, to work regularly in this area.

Other calls have come in with other offers of assistance.

"Several home nursing services have

called to let us know they will offer their services on the same free or reduced cost basis as the physicians, and a local dentist called us with a similar offer," Clinger says. Various laboratories around the city have expressed cooperation, and Columbus City Commissioner Michael Dorrian has told Academy staff members that medically indigent individuals needing skilled nursing care in nursing homes will be accommodated at reduced rates.

"Project Health Concern is a community effort made possible by a variety of health care professionals," Clinger sums up — and the community has gratefully responded.

"We have been able to refer most of our callers back to their own physicians for help," Clinger says.

"Most of them had been hesitant to use their own physicians in their current financial straits, but we tell them to explain their situation to their physicians and to continue seeing him or her for their medical care." Even still, a good many callers have preferred to let Academy staff members do the explaining.

"When a caller seems hesitant about getting in touch with their physicians, we offer to do it for them, and most accept quite willingly," Clinger says.

As a result, the Academy has had to make very few new referrals, but even those have worked out well.

"We had a patient call us back after having seen a physician we referred her to. She wanted to tell us how well she had been treated by the physician and staff, and how pleased she was with the program."

Project Health Concern is just one example of how Ohio physicians are meeting the needs created by today's capricious economy. An old-fashioned illustration of neighbor helping neighbor. . . Karen Edwards



Volunteer Joan Merkle (far left), project coordinator Ann Clinger and Columbus Academy of Medicine staff member Carol Edgar answer the public's questions about Project Health Concern.

Response from the counties has, for the most part, been enthusiastic, although some feel that adequate assistance already is being provided.

system. . . with "public health centers all over the city."

Not every city, however, seems to be so well-endowed, and many — such as Columbus, Cleveland and Medina County — have embraced this new project like an old friend.

The Cleveland Academy of Medicine was the first to announce its "Project '83" — the program it designed to provide medical care for the county's unemployed, at a press conference held in late January.

Ray W. Gifford, Jr., M.D., Academy President, joined Cleveland Mayor George V. Voinovich in explaining how the program would operate.

"We are encouraging the jobless to continue going to the same doctors they saw before losing health coverage — and doctors are being encouraged to continue the care they were giving," Dr. Gifford announced at the conference.

In addition, physicians were asked to voluntarily accept a few new patients who are unable to pay for health care because of unemployment.

"In the first two days of recruiting, 100 doctors volunteered for the program," Gifford said.

The free care, under the Cleveland Academy's program, will be available to county residents who lost their jobs after December 31, 1980, and who have no health insurance. That could be as many as 300,000 people, Dr. Gifford estimated, if family members are included.

The Cuyahoga County Medical Foundation (a charitable-educational foundation established by the Academy of Medicine of Cleveland) is trying to raise \$68,000 to finance an office with one or two nurses, a secretary and others to take calls and refer patients to volunteer physicians.

For the city's part, Voinovich announced that the city was adding additional doctors, nurses and health professionals to its health centers to help care for a patient load increase of about 20%.

"Project '83 is a temporary program and we will review it every six months," Dr. Gifford recently wrote in a letter to the membership. "Among the criteria used to determine the need to continue or discontinue the project will be the level of unemployment in the community, and the number of requests for assistance."

A similar six-month program has just been launched by Cleveland's neighbor, Medina County.

The project's chairman, William D. Smucker, M.D., anticipates that a minimum of 80% of the membership will participate in the program.

"The Medina County Medical Society is aware that growing unemployment has caused many workers to lose their health insurance coverage and, as a result, they are reluctant to seek medical care," writes Medina County President, H. L. Mast, M.D., in a letter to members. "While we believe relatively few people are in this situation, the Society thinks physicians should assure that no person goes without needed medical care. In this spirit, the Society has designed a program to help physicians meet the needs of these people. We call our program 'Project '83.'"

As with the Cleveland program, physicians are first being asked to continue to care for their patients who may have lost their jobs.

"That may mean that our newer physicians will have a slightly bigger caseload," says John Gerding, Executive Director of the Medina County Medical Society. As he explains, the newer physicians are the

ones who are most likely seeing the newer, younger patients — who, in turn, are generally the first victims of an employment layoff.

"Those unemployed without physicians will be taken care of on a rotation basis," says Gerding.

The Medical Society has turned to a local community services center for help in screening qualified participants for the program.

"The Center systematically reviews needy applicants for other programs, so our project simply will become part of a package deal offered to those who are qualified," Gerding said.

The Center will have a list of those physicians participating in the program, and they will make the appointments for the applicants.

"That way, the physicians will know the applicant is qualified to receive the free care," Gerding said.

The local dental society will be joining the Medina Medical Society in their free/reduced cost project.

While both Dayton and Toledo are planning similar programs for their unemployed, each were still in the discussion stages at the time of writing.

Not so in Columbus, however. James Barnes, M.D., President of the Academy of Medicine of Columbus and Franklin County, was one of the first to respond positively to Dr. Ford's letter when it arrived in late December.

"It comes as no surprise to any of us that hard times have finally reached Columbus," he wrote in a letter to the membership. "Many of our neighbors are currently unemployed, uninsured and ineligible for Medicaid or other existing assistance programs. It's our responsibility to respond to this problem."

Although there were some

continued on page 259

Candidates for nutritional therapy...

10,000,000

alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.¹

25,500,000 geriatric

patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.²

23,500,000 surgical

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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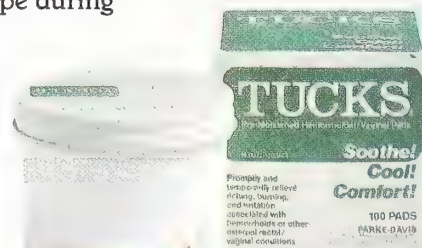
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"We hope we are saying 'come to physicians now', don't put it off until the problem gets worse . . ."

James Barnes, M.D. Columbus

questions, some initial reservations, the idea for the project was, for the most part, enthusiastically received.

"We agree that all physicians in Columbus and Franklin County should share the burden (of care for the newly medically indigent patients). . ." wrote one member, in response to Dr. Barnes' letter. Another commented: "I am writing to say how impressed I am with your proposal for the care of the newly medically indigent. . ."

Nearly 500 Columbus physicians have volunteered to participate in the program to date, and backed with this kind of support, Dr. Barnes, his new Project Health Concern Committee, and Academy staff members took their project to the community's other health care professionals.

"We wanted to be able to present a project that would be a coordinated effort with other health care professions in the city," says Ann Clinger, Administrative Assistant for the Academy who is serving as the project's coordinator.

As a result, when the story was finally given to the media at a press conference held in late February, representatives from the Osteopathic Academy, the city health department, Columbus' hospitals and pharmacists were able to meet with Dr. Barnes to discuss their own parts in the project.

"We estimate that 20% of those receiving free or reduced-cost care will be treated by osteopaths," says William Lindner, D.O., President-Elect of Columbus' Osteopathic Academy of Medicine, at the press conference. "Our Academy is supporting this effort wholeheartedly."

"And we'll see to it that patients receive the hospital care they need," says Charles Turner, Acting Executive Director of the Coalition for Cost Effective Health Services, who was representing Columbus area hospitals.

Paul Hafner, R.P.H., Chairman of the Interprofessional Relations Committee, Central Ohio Society of Hospital Pharmacists, announced two cost-cutting measures which pharmacists would soon implement to reduce the cost of prescription medicine for the medically indigent.

"We will adjust the fees the pharmacists receive from filling prescriptions, as well as distribute lists to both pharmacists and physicians in this area which will suggest medication which can be filled by cheaper, generic equivalents," he says. "In this way, we hope we can hold claim costs down to a reasonable level."

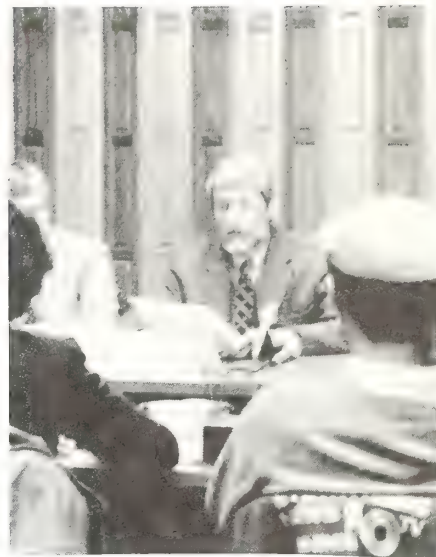
Columbus' six-month project will be operated in much the same manner as Cleveland's, with eligible participants able to continue seeing their own physicians; referred to a neighborhood health center; or referred to one of the physicians who have volunteered to participate in the program.

"Referrals will be made on an individual basis," says Dr. Barnes, "and every effort will be made to provide them with medical care in their home area — whether that represents a neighborhood health center, or one of our volunteer physicians."

Dr. Barnes admits that this may put an undue burden on some physicians — especially those who work in areas heavily populated by blue collar workers who all may have been recently laid off from their jobs.

"But we will make every effort to make the distribution as equal as possible, and to make referrals on a rotational basis," Dr. Barnes says.

"By initiating this project, we hope we are saying 'come to physicians now,' don't put it off until the problem gets worse, and as an aside, ultimately more costly," Dr. Barnes says.



Columbus Academy President James Barnes discusses Project Health Concern at a press conference earlier this year.

"We hope, too, that this project will serve as a basis for more cooperation among the health care professions in town," adds William Myers, Commissioner of the Columbus Health Department.

Certainly the spirit seems to be there, not just in Columbus, but all over the state. Perhaps Dr. Barnes' enthusiasm seems to sum up the feeling best.

"Columbus has a problem, and Columbus has responded to it. We haven't had to turn elsewhere, or to someone else for an answer. We're handling it ourselves. And I can't imagine anyone **not** responding. I think it's one of those cases where 500 physicians have responded, but if you specifically called someone up who has not responded and asked if they could take care of a Project Health Concern patient, they'd do it. We're taking responsibility for our own. It shows, I think, Columbus is a neat place to live. . ."

And so, it would seem, is anyplace in Ohio.

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal.



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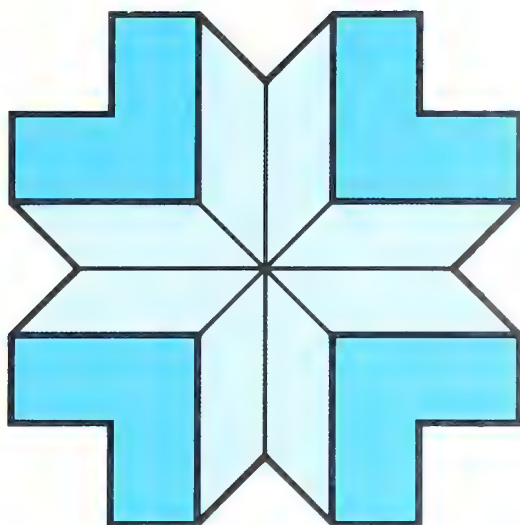
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The 1983 OSMA Annual Meeting

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The Candidate for President- Elect

A. Burton Payne, M.D.

A. Burton Payne, M.D., Ironton, has been nominated for the office of president-elect of the Ohio State Medical Association. His name was placed in nomination by the Lawrence County Medical Society. On July 26, 1982, Society President James B. Zimmerman, M.D. (now deceased), wrote the following letter:

Hart F. Page, Executive Director
Ohio State Medical Association
600 High St.
Columbus, Ohio 43215

Dear Mr. Page,

The Lawrence County Medical Society is pleased to nominate A. Burton Payne, M.D., Ninth District Councilor, for the office of President Elect of the Ohio State Medical Association.

Dr. Payne has demonstrated outstanding leadership qualities and total commitment to organized medicine at all levels. He is held high in repute as a physician by his peers.

In consideration of his proven leadership ability and his contributions to organized medicine, we are proud to nominate Dr. A. Burton Payne as a candidate for the office of President Elect.

Sincerely

James B. Zimmerman, M.D.

President

Lawrence County Medical Society

Born in Lawrence County, Ohio, A. Burton Payne, M.D., received his B.Sc. from Ohio State University in 1950, then entered Ohio State University's College of Medicine from which he graduated in 1956.

Following a rotating internship at Grant Hospital in Columbus, Ohio, Dr. Payne set up a general practice in Ironton, Ohio, but returned to Ohio State University Hospital in 1959 for a residency in anesthesiology. He received his Masters in medical science from Ohio State in 1961, then returned to Ironton where he added anesthesiology to his general practice. In 1977, Dr. Payne chose to limit his practice to anesthesiology — and he has continued to do so today.

On the active staff at Lawrence County General Hospital in Ironton, Dr. Payne served as Chief of Staff in 1973 and 1974.

Although Dr. Payne has served on the OMPAC Board since 1967, his involvement with the Ohio State Medical Association (OSMA) actually began in 1970, when he served as a delegate from Lawrence County. He served as Chairman of the Reference Committee in 1974, and on the

Professional Liability Task Force from 1974-1982. Dr. Payne has been a member of the OSMA Council since 1978, and has served as Chairman of both the Legislation and Auditing and Appropriations Committee. He continues to serve as Chairman of the OMPAC Board.

Dr. Payne also is actively involved with PICO, OSMA's Physicians Insurance Company. He has served on its Board of Directors since 1976, and has served as Chairman of the Board of PICO Life since 1981.

Dr. Payne is as actively involved outside the Association as he is within it. Politically, he has served as Lawrence County's Commissioner, as a member of the Central Committee, and as Chairman of Lawrence County's Republican Executive Committee.

He is also a member of the Ohio Valley Health Service Foundation, and is a Director of the BancOhio National Bank in Ironton.

Dr. Payne lives in Ironton with his wife, Leona, their son, James and their daughters, Patricia, Judith, Teresa and Susan.

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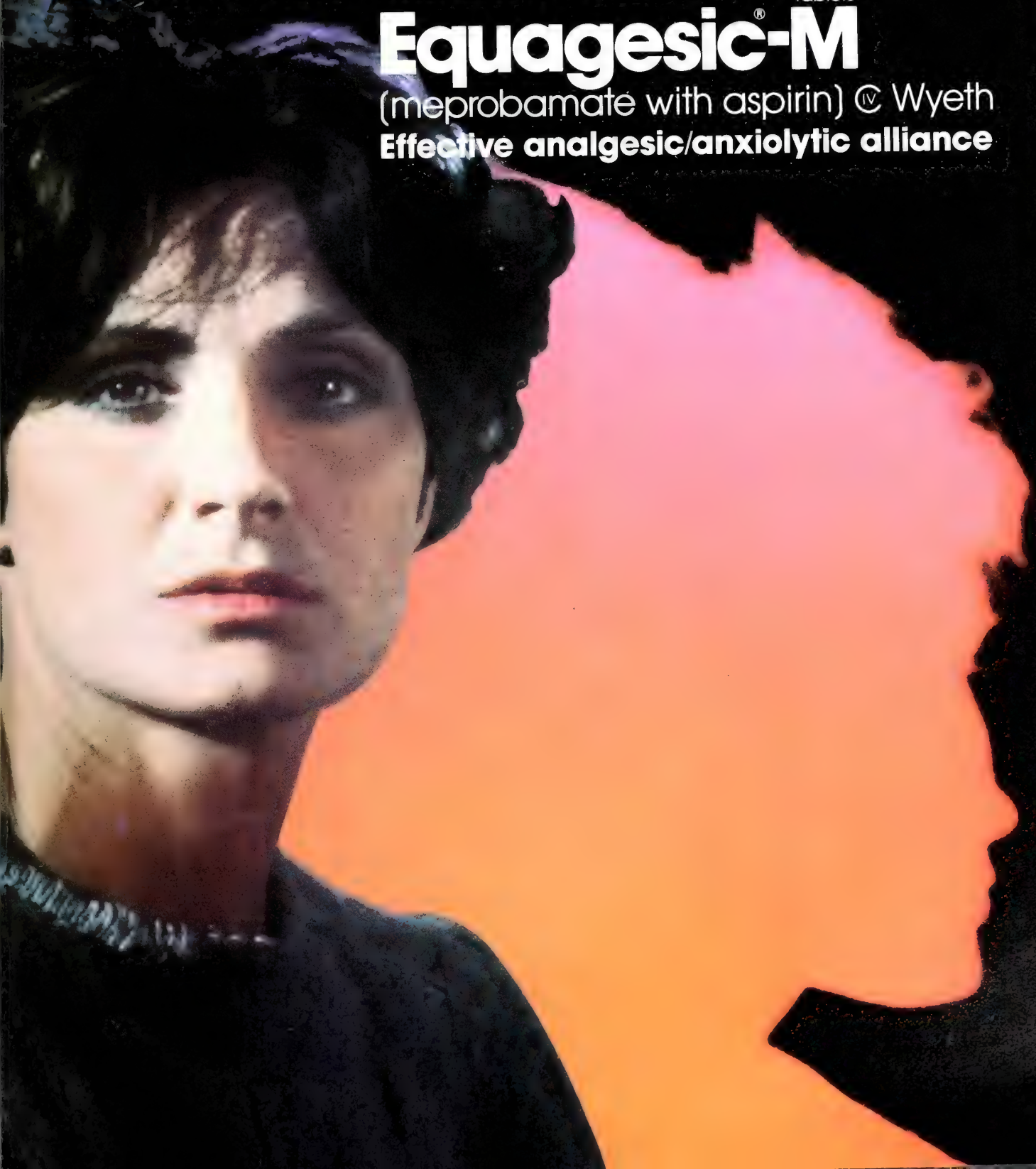


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within next 12 to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIONAL EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

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MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. GI: Nausea, vomiting, diarrhea. CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis. ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, pechlecho, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate, mebutamate and meprobamate-carbimol. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and

bullous dermatitis have occurred. **HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC")** Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSEAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE: Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoadidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal.

The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdosage (meprobamate alone). Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS: 0.5-2.0 mg percent represents usual blood-level range after therapeutic doses. The level may occasionally be as high as 3 mg percent, during severe overdosage. 3-10 mg percent usually corresponds to

findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur. At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdosage (meprobamate with other psychotropic drugs or alcohol). Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED: Bottles of 50 scored tablets.

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OHIO MEDICINE AT THE CENTER

OSMA 1983 ANNUAL MEETING

May 13-18, 1983

(All programs are scheduled at the Hyatt Regency/Columbus at the Ohio Center unless otherwise indicated.)

ANNUAL MEETING FORMAT

Friday, May 13

OSMA COUNCIL MEETING/BREAKFAST Morrow Room	8:30 AM
OMPAC BOARD Luncheon — Champaign Room	12:00 Noon
EMERGENCY RESOLUTION COMMITTEE Luncheon/Meeting — Board Room #2	12:00 Noon
OSMA DELEGATION TO AMA Meeting — Fayette Room	1:00 PM
COUNCILOR DISTRICT CAUCUS District 1 — Marion Room District 5 — Knox Room Districts 2, 3, 4, 6, 7, 8, 9, 10, 11, 12 and students	4:00 - 5:30 PM In assigned suites (to be announced)
HOUSE OF DELEGATES Registration — Ballroom Foyer Sit-down Dinner — Regency Ballroom N Opening Session — Regency Ballroom S	3:00 - 7:00 PM 5:30 PM 7:00 PM
FOLLOWING HOUSE OF DELEGATES Reception hosted by the Academy of Medicine of Columbus & Franklin County	Franklin A & B

Saturday, May 14

REFERENCE COMMITTEES Breakfast — Regency Ballroom N Hearings	7:00 AM 8:00 - 11:30 AM
Committee No. 1, Delaware A Committee No. 2, Delaware B Committee No. 3 & President's Address, Delaware C Nominations Committee, Champaign Room into Executive Session (same rooms as earlier) Drafts & Reports	 1:30 PM 9:00 PM
Prepared and Reviewed by Committees	
OMPAC Social Hour & Luncheon Regency Ballroom N & Regency N Foyer	11:30 AM - 1:30 PM
PACO PROGRAM PACO Medical Computer Systems (computer demonstration) — Madison Room	2:00 - 5:00 PM
MEDICAL MUTUAL & OMIM Combined Reception — Marion & Morrow Rooms	5:00 - 7:00 PM

THEATRE PRODUCTION "Morning's at Seven" — Players Theatre of Columbus	8:00 PM
AFTER THEATRE PARTY — Marion & Morrow Rooms	10:00 PM

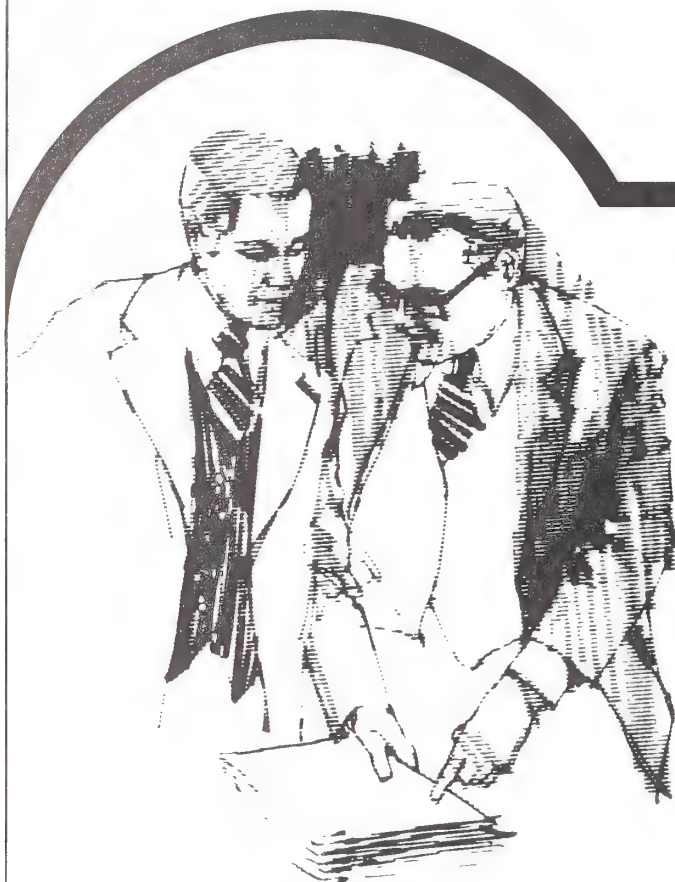
Sunday, May 15

DISTRICT CAUCUS Meetings (Reports ready) District No. 1 — Marion Room District No. 5 — Knox Room Districts 2, 3, 4, 6, 7, 8, 9, 10, 11, 12 and students	8:00 AM In assigned suites (to be announced)
HOUSE OF DELEGATES Registration — Regency Ballroom S Foyer Final Session — Regency Ballroom S Sit-down Dinner — Regency Ballroom N Resume Final Session (if necessary) — Regency Ballroom S	11:30 AM 1:00 PM 6:00 PM 7:00 PM

Monday, May 16

OTOLARYNGOLOGY Scientific Session Delaware D Luncheon Delaware C	8:00 AM - 5:30 PM 12:00 Noon
OSMA COUNCIL Meeting/Breakfast Madison Room	8:30 AM
HEALTH COMMISSIONERS Meeting Morrow Room	8:30 AM - 4:00 PM
SPORTS MEDICINE Meeting Union A & B Luncheon Union D & E	8:30 AM - 4:00 PM 11:40 AM
NEUROLOGY Scientific Session Knox Room	8:30 AM - 12:00 Noon
OHIO COMMITTEE ON TRAUMA, A.C.S. Scientific Session Union C	9:00 AM - 12:00 Noon

continued on page 269



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PSYCHIATRY
Scientific Session 8:30 AM - 5:30 PM
Delaware A & B
Luncheon 12:15 AM - 2:00 PM
Regency Ballroom N

UROLOGY
Scientific Session 9:00 AM - 3:00 PM
Champaign Room
Luncheon 12:00 Noon
Clark Room

PICO
Shareholders Meeting 10:00 AM
Marion Room

RHEUMATOLOGY
Luncheon 12:00 Noon
Fayette Room
Scientific Session 1:30 - 5:30 PM
Madison Room

EMERGENCY MEDICINE
Meeting 1:00 - 5:00 PM
Union C

FAMILY PRACTICE
Scientific Session 1:00 - 4:00 PM
Marion Room

PATHOLOGISTS
Board of Governors 4:00 - 6:30 PM
Clark Room

NEUROSURGERY
Business Meeting 4:00 - 6:00 PM
Cocktail Hour 7:00 - 8:00 PM
Dinner 8:00 - 10:00 PM
(All Monday events at Columbus Club,
181 East Broad Street.)

Tuesday, May 17

OPHTHALMOLOGY
Scientific Session 8:00 AM - 5:00 PM
Delaware A & B
Luncheon 12:00 Noon
Delaware C

HEALTH COMMISSIONERS
Meeting 8:30 AM - 4:00 PM
Morrow Room

PATHOLOGY
Scientific Session 8:30 AM - 5:00 PM
Union A
Luncheon 12:00 Noon
Delaware A

INTERNAL MEDICINE
Scientific Session 8:30 AM - 12:00 Noon
Union E

NEUROSURGERY
Scientific Session 9:00 AM - 4:15 PM
Union B
Luncheon 12:15 - 1:30 PM
Fayette Room

PHYSICAL MEDICINE & REHABILITATION
Luncheon 11:30 AM - 1:00 PM
Champaign Room
Scientific Session 1:30 - 5:00 PM
Marion Room
Cocktails & Poolside Barbeque 6:30 PM
Stouffer's Dublin Hotel
600 Metro Place North, Dublin

COLON & RECTAL SURGERY
Luncheon 12:00 Noon - 1:30 PM
Clark Room
Scientific Session 2:00 - 5:00 PM
Madison Room

DERMATOLOGY
Scientific Session 1:00 - 5:00 PM
Union C

Wednesday, May 18

PLASTIC SURGERY
Scientific Session 8:30 AM - 12:30 PM
Union B
Luncheon 12:30 PM
Knox Room

ALLERGY & IMMUNOLOGY
Scientific Session 8:30 AM - 12:10 PM
Union A
Luncheon 12:30 PM
Fayette Room

Meeting Room Locations

Hyatt Regency at Ohio Center

Second Floor
Board Room 1
Board Room 2
Clark
Champaign
Delaware (A, B, C, D)
Fairfield
Fayette
Franklin (A, B, C, D)
Knox
Madison

Marion
Morrow
Pickaway
Union (A, B, C, D, E)

Third Floor
Regency Ballroom
Regency North
Regency South
Atrium

Coming in the May Journal

The Aging of America

Are We Ready?

Experts in geriatric medicine will take a look at some of the problems medicine will be facing in the future as America's aging population continues to increase.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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continued on page 275

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BRIEF SUMMARY

Indications: Hypertension, adjunctive therapy in edema.

Contraindications: Anuria, hypersensitivity to chlorthalidone or other sulfonamide-derived drugs.

Warnings: Should be used with caution in severe renal disease, impaired hepatic function or progressive liver disease. May add to or potentiate the action of other antihypertensive drugs. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. There is a possibility of exacerbation or activation of systemic lupus erythematosus with thiazides, which are related to chlorthalidone. This has not been reported with chlorthalidone. Thiazides cross the placental barrier and appear in cord blood. Use in pregnant women requires that the anticipated benefits of the drug be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. In nursing mothers, thiazides cross the placental barrier and appear in breast milk. If use of the drug is essential, the patient should stop nursing.

Precautions: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving chlorthalidone should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia.

Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic

therapy. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance.

Adverse Reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis; dizziness, vertigo, paresthesias, headache, xanthopsia; leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia; purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis) (cutaneous vasculitis), Lyell's syndrome (toxic epidermal necrolysis). Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. Other adverse reactions include hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, impotence. Whenever adverse reactions are moderate or severe, chlorthalidone dosage should be reduced or therapy withdrawn.

Usual Dose: One tablet daily.

How Supplied: Tablets—100 mg. (white, scored), 50 mg. (aqua) in bottles of 100, 1000 and 5000; 25 mg. (peach) in bottles of 100 and 1000; unit-dose blister packs, boxes of 100 (10 x 10 strips).



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125-B

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PICKAWAY COUNTY

Delegate:
Ray Carroll
Alternate:
Charles Hedges

ROSS COUNTY

Delegate:
Joseph S. McKell
Alternate:
Donald L. Berling

UNION COUNTY

Delegate:
Paul R. Zaugg
Alternate:
Walter Burt

11th District

ASHLAND COUNTY

Delegate:
Jon H. Cooperrider
Alternate:
Paul Sauder

ERIE COUNTY

Delegate:
James Hart
Alternate:
William Birmingham

HOLMES COUNTY

Delegate:
Luther W. High
Alternate:
Maurice E. Mullet

HURON COUNTY

Delegate:
Nino M. Camardese
Alternate:
Carl D. Obenauf

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Delegates:
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Francisco Floro
Feite Hofman
Alternates:
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Daniel Zaworski

MEDINA COUNTY

Delegate:
Richard Avery
Alternate:
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RICHLAND COUNTY

Delegates:
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Alternates:
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Delegate:
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Medical Director

HERBERT A. SIHLER, JR.
President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

Alternate:
John Thomas

12th District

PORTAGE COUNTY

Delegate:

Donald Hammel

Alternate:

Michael Mastromatteo

SUMMIT COUNTY

Delegates:

Fred D. Barton
Joseph J. Bastolla
Charles V. Bowen
Aris W. Franklin
W. Paul Kilway
Fred F. Somma
Jack L. Summers
Francis J. Waickman

Alternates:

William Dorner, Jr.
Charles A. East
Paul D. Gatewood
Armond L. Leiby
Robert E. Marsico
E. Gates Morgan
J. Joseph Payton
Michael D. Serene

Cleveland Clinic Symposium

SECOND INTERNATIONAL SYMPOSIUM AND EXHIBIT ON PLASMAPHERESIS: THERAPEUTIC APPLICATIONS AND NEW TECHNIQUES: April 25-26; Hollenden House, Cleveland; sponsor: Cleveland Clinic Educational Foundation; cosponsor: International Society for Artificial Organs; 14 credit hours; fee: \$150 for members, \$200 for nonmembers; contact: Mary Ann Edsall, ISAO, 8937 Euclid Avenue, Cleveland 44106, phone: 216/444-2470.

1983 Annual Meeting Specialty Section Representatives

OHIO SOCIETY OF ANESTHESIOLOGY

Delegate:

Nicholas G. DePiero

Alternate:

Harold R. Stevens

OHIO ACADEMY OF FAMILY PHYSICIANS

Delegate:

Gene E. Wright

Alternate:

Leroy D. Rodgers

OHIO STATE NEUROSURGICAL SOCIETY

Delegate:

Edward J. Kosnik

Alternate:

Robert P. Schwetzenau

OHIO SECTION FOR AMERICAN COLLEGE OF OB- GYN

Delegate:

James R. Huey, Jr.

Alternate:

Tom Halliday

OHIO ORTHOPAEDIC SOCIETY

Delegate:

Robert S. Heidt, Sr.

Alternate:

Warren G. Harding

OHIO SOCIETY OF PATHOLOGISTS

Delegate:

Victor H. Hinrichs

Alternate:

William T. Collins

OHIO CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

Delegate:

Richard D. Ruppert

Alternate:

William H. Bunn

OHIO PSYCHIATRIC ASSOCIATION

Delegate:

Thomas R. Werner

Alternate:

Daniel A. Deutschman

OHIO STATE RADIOLOGICAL SOCIETY

Delegate:

S. Theodore Pinsky

Alternate:

Samuel L. Hissong

OSMA SECTION ON DERMATOLOGY

Delegate:

Bartholomew D. Ragucci

Alternate:

OHIO SOCIETY OF PHYSICAL MEDICINE & REHABILITATION

Delegate:

James Jay Powers

Alternate:

Watson Parker

OHIO SOCIETY OF OTOLARYNGOLOGY

Delegate:

Leo T. Wagenbrenner

Alternate:

Don E. Gebhart



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Announces The Third Continuing Education Course
On

BALANCE DISORDERS

Thursday, April 28, 1983

Credits: Approved for 7 Credit Hours Category I for the Physician's Recognition Award of the AMA. Acceptable for 7 Prescribed Hours by the American Academy of Family Physicians.

Course: This course is designed for the family practitioner and the many various specialists seeking better understanding and improved competence in the diagnosis and management of the patient with any form of dizziness or disequilibrium. The registration fee is \$30.00 and includes the course-related materials, luncheons, refreshments and cocktails. The topics covered will include:

Topics: Bone Marrow Examination, Clinical Application; Plasma Cell and Blood Protein Disorders; Auditory Brainstem Evoked Potentials, ENG, Impedance Audiometry, Application to Clinical Otology; Management of Otitis Media in Children; Surgical Management of Vertigo; Recent Advances in Anti-Microbial Therapy; Hyperlipidemia; Parkinsonism, Plus Syndrome; Hypoglycemia; Clinical Management of Acute Hypersensitivity Syndrome.

Chairman: **Hong I. Seung, M.D.**, Clinical Assistant Professor, Otolaryngology-Head and Neck Surgery, West Virginia University School of Medicine, Morgantown, West Virginia. Senior Staff, Wheeling Hospital and Ohio Valley Medical Center, Wheeling, West Virginia

Speakers: **Joseph R. Bianchine, M.D.**, Professor and Chairman, Department of Pharmacology; Professor of Medicine, Ohio State University, College of Medicine, Columbus, Ohio.

Thaddeus S. Danowski, M.D., Clinical Professor of Medicine, University of Pittsburgh, School of Medicine; Director of Medicine, Shadyside Hospital, Pittsburgh, Pennsylvania.

Heinz F. Eichenwald, M.D., Professor and Chairman, Department of Pediatrics, University of Texas, Health and Sciences Center, Dallas, Texas.

Michael Glasscock III, M.D., Clinical Professor of Otolaryngology, Vanderbilt University, School of Medicine, Nashville, Tennessee.

Bong H. Hyun, M.D., D. Sc., Professor of Pathology, Rutgers Medical School; Director, Department of Pathology, Muhlenberg Hospital, Plainfield, New Jersey.

Lodging: Overnight Accommodations: Physicians should directly contact the reservation manager of hotel or motor inn of their choice. Suggestions: Howard Johnson's 1-800-654-2000 and Wheeling Inn (304) 233-8500. For golf reservations at Oglebay Park's Speidel Course, call (304) 242-3000, Extension 156. For tennis reservations, (304) 242-3770 (indoor, Wheeling Park) or (304) 242-3000, Extension 139 (outdoor, Oglebay Park). For further information contact Dr. Elliott at Wheeling Hospital (304) 242-7870.

Registration Form BALANCE DISORDERS Thursday, April 28, 1983

Name _____ Specialty _____

Address _____ City _____ State _____

Registration fee is \$30.00. Please make checks payable to Wheeling Hospital and mail with this form to Terry Elliott, M.D., Continuing Medical Education, Wheeling Hospital, Medical Park, Wheeling, WV 26003.

DELEGATES AND ALTERNATES SCHEDULE

FRIDAY, MAY 13

3:00 - 7:00 PM

Registration for OSMA House of Delegates
Ballroom Foyer, Third Floor, Ohio Center

4:00 PM

Councilor District Caucus Meetings
Caucus Suites will be posted at the Registration
Desk.

5:30 PM

Dinner for Delegates, Alternates, OSMA Council
and Official Guests
Regency Ballroom North, Third Floor, Ohio Center

7:00 PM

Opening Session, OSMA House of Delegates
Regency Ballroom South, Third Floor, Ohio Center

BUSINESS AGENDA OPENING SESSION

Call to Order

C. Douglass Ford, M.D., Toledo
President

Invocation

Lester Parker, M.D., Sandusky

Welcome

James E. Barnes, M.D., Columbus
President, Academy of Medicine of
Columbus and Franklin County

Report

Committee on Credentials

Consideration of Minutes of 1982 Annual Meeting

(See July 1982 issue of The Ohio
State Medical Journal)

Introduction of Members, AMA Board of Trustees

Introduction of Honored Guests

Report

Mrs. Rose Vesper, New Richmond
OSMA Auxiliary President

Special Awards

AMA-ERF Presentations

Philip B. Hardymon, M.D.,
Columbus
Chairman, Ohio Committee on
AMA-ERF

Presentation of Plaques

To past Councilors, retiring AMA
Delegates and Alternates and
Chairmen of Committees

Announcement

C. Douglass Ford, M.D., Toledo

Appointments to Resolutions

Committees, Credentials, and Tellers
and Judges of Election Committees.

Elections of Committee on Nominations Nominations from the floor. One

representative (delegate) from each
Councilor District. The committee
shall report to the second and final
session, Sunday, May 15, 1:00 PM,
its recommendations in the form of
a ticket containing nominees for
offices to be filled at this meeting as
required under the Constitution and
Bylaws. Under the rotation plan
established in 1963, the
committeeman from the Tenth
District shall serve as Chairman. The
report of the Nominating Committee
with respect to all offices except
President-Elect shall be posted at the
registration desk, earliest time
practicable and at least three hours
before the final session of the House
of Delegates.

President's Address

C. Douglass Ford, M.D., Toledo

Introduction of Presidents of Other State Societies

FRIDAY, MAY 13

continued

Introduction of Representatives of Allied Organizations

Introduction of Resolutions—

Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Sunday afternoon session before any action can be taken.

Miscellaneous Business

SATURDAY, MAY 14

7:00 - 8:00 AM

Buffet Breakfast for Delegates, Alternates, OSMA Council and Official Guests
Regency Ballroom North, Third Floor, Ohio Center

8:00 - 11:30 AM

Reference Committee Hearings, Ohio Center
Res. Committee No. 1 - Delaware A
Res. Committee No. 2 - Delaware B
Res. Committee No. 3 - Delaware C
& President's Address
Nominating Committee - Champaign Room

SUNDAY, MAY 15

9:00 AM

Councilor District Caucus Meetings
Caucus suites will be posted at the Registration Desk

11:30 AM - 1:00 PM

Registration for OSMA House of Delegates
Ballroom Foyer, Third Floor, Ohio Center

1:00 PM

Final Session, OSMA House of Delegates
Regency Ballroom South, Third Floor, Ohio Center

6:00 PM

Dinner for Delegates, Alternates, OSMA Council and Official Guests
Regency Ballroom North, Third Floor, Ohio Center

7:00 PM

Continuation of Final Session (if necessary)

ORDER OF BUSINESS FINAL SESSION

Introduction of Guests

Presentation of Journal Photographic Awards

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

Election of Members of The Council
Members of The Council are elected for two-year terms; terms of those representing the even-numbered districts expire in odd-numbered years. Second District: Incumbent, Herman I. Abromowitz, Dayton;

Fourth District: Incumbent, Benjamin H. Reed, Wauseon; Sixth District: Incumbent, J. James Anderson, Youngstown; Eighth District: Incumbent, Carl E. Spragg, New Concord; Tenth District: Incumbent, D. James Hickson, Mt. Gilead; Twelfth District: Incumbent, Joseph L. Kloss, Akron.

Election of Delegates and Alternates to the AMA

Seven Delegates and seven Alternates to be elected for a two-year term starting January 1, 1984, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1983, their terms expiring December 31, 1983.

Delegates (listed alphabetically): John E. Albers, Cincinnati; George N. Bates, Toledo; Oscar W. Clarke, Gallipolis; Alford C. Diller, Van Wert; William Dorner, Jr., Akron; John J. Gaughan, Cleveland; B. Leslie Huffman, Jr., Maumee. Alternates (listed alphabetically):

Herman I. Abromowitz, Dayton; David A. Barr, Lima; C. Douglass Ford, Toledo; Edward E. Grable, Canton; Stanley J. Lucas, Cincinnati; Thomas W. Morgan, Gallipolis; Richard J. Nowak, Cleveland.

All nominees for the offices of AMA Delegates and Alternate Delegates shall run at large. Election of Delegates and Alternate Delegates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

****SPECIAL ORDER OF BUSINESS**
(after-dinner break)
Installation of 1983-1984 Officers

Reports of Reference Committees

Resolutions Committee No. 1;
Resolutions Committee No. 2;
Resolutions Committee No. 3 and
President's Address

Miscellaneous Business

Announcement

S. Baird Pfahl, Jr., M.D.
Sandusky
President

Unfinished Business

Adjournment

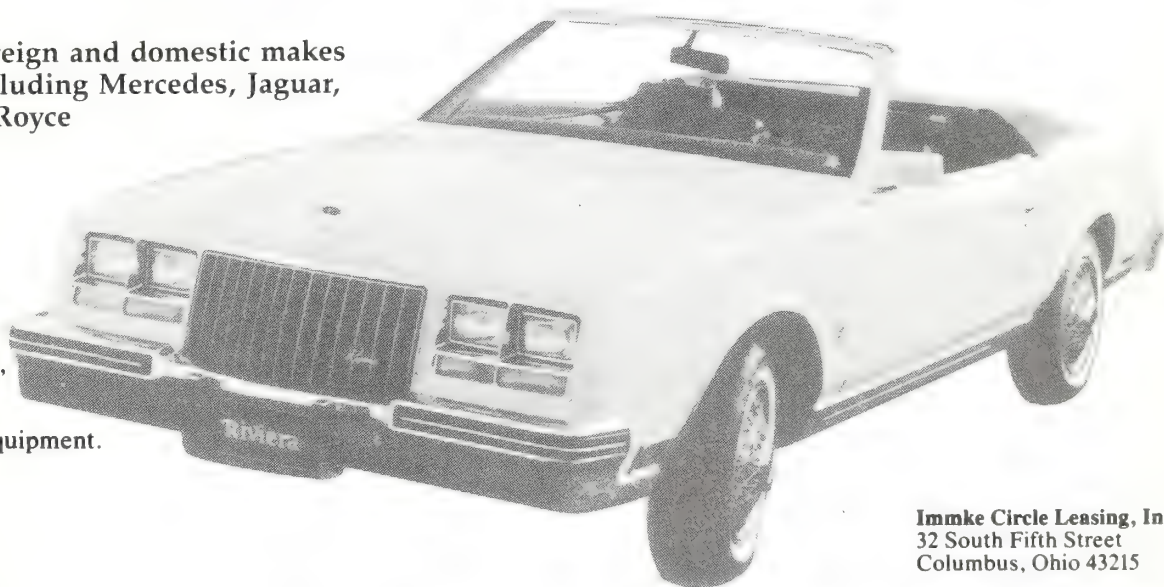
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Sharing ownership in American Physicians Life are Physicians Insurance Company of Ohio, the major shareholder, representing Ohio physicians; the Indiana State Medical Association, representing Indiana physicians; Physicians Insurance Company of Michigan, representing Michigan physicians; and Kentucky Medical Insurance Company, representing Kentucky physicians. American Physicians Life is establishing operations throughout the midwest, in cooperation with other medical associations and physician-owned entities.

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Continuing Medical Education Courses

ALLERGY AND IMMUNOLOGY

CME Hours:
3 Category I

Date:
Wednesday, May 18

Place:
Union A, Hyatt Regency/Columbus
at Ohio Center

Time:
8:00 AM to 12:10 PM

Sponsor:
OSMA Section on Allergy and Ohio
Society of Allergy & Immunology

Schedule:

8:00 - 8:15 AM
Introduction
— *James I. Tennenbaum, M.D.*,
Columbus

8:15 - 9:00 AM
Techniques in Allergy - Proven
and Unproven
— *S. Roger Hirsch, M.D.*,
Associate Clinical Professor of
Medicine, Medical College of
Wisconsin, Milwaukee, Wisconsin

9:00 - 9:10 AM
Questions and Answers

9:10 - 9:50 AM
Acquired Immunodeficiency
Disease Syndrome (AIDS)
— *Roger A. Friedman, M.D.*,
Columbus

9:50 - 10:00 AM
Questions and Answers

10:00 - 10:15 AM
Coffee Break

10:15 - 11:00 AM
Allergic Ear Disease
— *Phillip Fireman, M.D.*, Chief,
Allergy, Pittsburgh Children's
Hospital, Pittsburgh,
Pennsylvania

11:00 - 11:10 AM
Questions and Answers

11:10 AM - 12:00 Noon
Occupational Asthma
— *David Bernstein, M.D.*,
Cincinnati

12:00 Noon - 12:10 PM
Questions and Answers

12:30 PM
Luncheon
— Fayette Room, Ohio Center

COLON AND RECTAL SURGERY

CME Hours:
3 Category I

Date:
Tuesday, May 17

Place:
Madison Room, Ohio Center

Time:
2:00 PM to 5:00 PM

Sponsor:
OSMA Section on Colon and Rectal
Surgery

Schedule:
12:00 Noon - 1:30 PM
Luncheon
Clark Room, Ohio Center

Thomas G. Hardy, Jr., M.D., Columbus,
Presiding

2:00 - 2:20 PM
Benefits and Pitfalls of Stool
Hemoccult Tests
— *Patrick Hagihara, M.D.*,
Lexington, Kentucky

2:20 - 2:40 PM
CEA Update, Inter-operative
Radioimmuno-detection
— *Edward W. Martin Jr., M.D.*,
Columbus

2:40 - 3:00 PM
Topic to be announced
— *Rene F. Hartmann, M.D.*,
Columbus

3:00 - 3:20 PM
Break

3:20 - 3:40 PM

Contact Radiation Therapy for
Carcinoma of the Rectum
— *Ian Lavery, M.D.*, Cleveland
Clinic, Cleveland

3:40 - 4:00 PM

Case of Acute Bowel Obstruction
Due to Unusual Etiology — Mini
CPC
— *Edward Hamilton, M.D.*,
Columbus

4:00 - 5:00 PM

Questions and Answers

DERMATOLOGY

CME Hours:

4 Category I

Date:

Tuesday, May 17

Place:

Union C, Ohio Center

Time:

1:00 PM to 5:00 PM

Sponsor:

OSMA Section on Dermatology

Topic:

A Dermatologic Primer for Summer

Schedule:

Robert H. Schosser, M.D., Course
Director & Presiding Officer,
Chairman, Department of
Dermatology, Wright State
University School of Medicine,
Dayton

Introduction

— *Harry H. Fox, M.D.*, Cincinnati,
Chairman OSMA Section on
Dermatology

1:00 - 1:50 PM

Sunshine - Enemy? Friend?: A
Game Plan
— *Robert H. Schosser, M.D.*,

1:50 - 2:45 PM

Plants That Make Us Itch
— *H. Michael Duke, M.D.*,
Assistant Professor of
Dermatology, Wright State
University School of Medicine,
Dayton

2:45 - 3:00 PM

Break

3:00 - 3:50 PM

Fleas, Ticks, Pets and Their
Owners
— *Robert H. Schosser, M.D.*
— *Thomas L. Cropper DVM*,
MPVM, Major, USAF, Wright
Patterson AFB, Dayton
— *Thomas Headding DVM, MPH*,
Lt. Colonel, USAF, Wright
Patterson AFB, Dayton

3:50 - 4:45 PM

Intertrigo, Jock Itch and Other
Miscellaneous Summer
Aggravated Misereries — Diagnosis
and Treatment
— *Dwight D. Smith, M.D.*,
Colonel, USAF, Associate
Professor of Dermatology, Wright
State University School of
Medicine and Wright Patterson
AFB, Dayton

FAMILY PHYSICIANS

CME Hours:

3 Category I

Date:

Monday, May 16

Place:

Marion Room, Ohio Center

Time:

1:00 PM to 4:00 PM

Sponsor:

Ohio Academy of Family Physicians
and OSMA Section on Family
Practice

Topic:

Family Physicians and Surgeons:
Allies or Adversaries?

Schedule:

1:00 - 1:20 PM

Panel Discussion

Moderator:

Larry C. Carey, M.D.

Robert M. Zollinger Professor of
Surgery, Chairman, Department
of Surgery, The Ohio State
University, Columbus

1:20 - 1:40 PM

Participants:

Carl Richard Coleman, M.D.,
Director of Orthopaedic
Education, Riverside Methodist
Hospital, Clinical Professor of
Orthopaedic Surgery, The Ohio
State University College of
Medicine, Columbus

1:40 - 2:00 PM

Break

2:00 - 2:20 PM

Ronald B. Berggren, M.D.,
Director, Division of Plastic
Surgery, Department of Surgery,
The Ohio State University,
Columbus

2:20 - 2:40 PM

Richard C. Bump, M.D., Assistant
Professor, Department of
Obstetrics & Gynecology, The
Ohio State University, Columbus

2:40 - 4:00 PM

Panel

Moderator: *Wilburn H.*

Weddington, M.D., Program
Chairman, Ohio Academy of
Family Physicians, Columbus

Tennyson Williams, M.D., Professor
and Chairman, OSU Department
of Family Medicine, Columbus

Robert Smith, M.D., Chairman,
Department of Family Medicine,
University of Cincinnati,
Cincinnati

Leroy A. Rodgers, M.D., Associate
Professor and Vice Chairman,
Department of Family Medicine,
Medical College of Ohio, Toledo

FETAL ALCOHOL SYNDROME

Date:

Wednesday, May 18

Places and Times:

Union C (meeting) 8:00 AM to 5:00
PM
Union D & E (luncheon) 12:00
Noon, Ohio Center

Sponsored by:
The Columbus Health Department

Faculty:
Jephtha R. Hostetler, Ph.D.;
Ruth Ann Holzhauser, M.D.;
Sterling K. Clarren, M.D.;
Nancy Golden, M.D.; and Luther K.
Robinson, M.D.

NEUROLOGY

CME Hours:
3½ Category I

Date:
Monday, May 16

Place:
Knox Room, Ohio Center

Time:
8:30 AM to 12:00 Noon

Sponsor:
OSMA Section on Neurology

Schedule:
George W. Paulson, M.D., Columbus,
Presiding Officer

8:30 - 9:00 AM
Advances in Immunology and in
the Immunotherapy of MS
— *Kottil Rammohan, M.D., Ohio*
State University College of
Medicine, Columbus

9:00 - 9:30 AM
24 Hour Ambulatory EEG
Recordings. Technique and
Results
— *David S. Bachman, M.D.,*
Columbus

9:30 - 10:15 AM
Update on EMG
— *Jack Warmolts, M.D., Ohio*
State University College of
Medicine, Columbus

10:15 - 10:45 AM
Difficult to Diagnose
Neuropathies
— *Henry Grinvalsky, M.D.,*
University of Cincinnati College
of Medicine, Cincinnati

10:45 - 11:15 AM
Diagnosis and Management of
Pseudoseizures
— *Miles E. Drake, M.D., Professor*
of Neurology & Director of EEG
and Evoked Potential Laboratory,
Ohio State University College of
Medicine, Columbus

11:15 - 12:00 Noon
Cleveland Clinic Report and
Report of a New Neurologic
Disorder in Central Ohio
— *Asa Wilbourn, M.D., Cleveland*
Clinic, Cleveland

NEUROSURGERY

CME Hours:
5 Category I

Dates:
Monday, May 16 and Tuesday, May
17

Place:
Monday (business meeting &
banquet) Columbus Club
Tuesday (meeting) Union B;
(luncheon) Fayette Room, Ohio
Center

Times:
Monday, business meeting, 4-6 p.m.
Monday, banquet, 7-10 p.m.
Tuesday, meeting, 9 a.m.-4:15 p.m.
Tuesday, luncheon, 12:15 p.m.

Sponsor:
Ohio State Neurosurgical Society &
OSMA Section on Neurosurgery

Schedule:
Monday, May 16:
4:00 - 6:00 PM
Business Meeting

7:00 - 8:00 PM
Cocktails

8:00 - 10:00 PM
Dinner
— *The Columbus Club, 181 E.*
Broad Street, Columbus

Tuesday, May 17
9:00 - 10:00 AM
Lessons Learned From
Intracranial Pressure Monitoring
— *Donald P. Becker, M.D.,*
Chairman, Department of
Neurosurgery, Medical College of

Virginia, Richmond, Virginia

10:00 - 10:15 AM
Discussion

10:15 - 10:35 AM
Coffee Break

10:35 - 11:20 AM
Respiratory Support in the Patient
With Increased Intracranial
Pressure: An Anesthesiologist's
Viewpoint
— *John T. Martin, M.D., Professor*
and Chairman, Department of
Anesthesiology, Medical College
of Ohio, Toledo

11:20 - 11:30 AM
Discussion

11:30 AM - 12:00 Noon
Intraoperative Monitoring of the
Neurosurgical Patient
— *Gerald Brodkey, M.D.,*
Department of Neurosurgery,
Cleveland Clinic, Cleveland

12:00 Noon - 12:15 PM
Discussion

12:15 - 1:30 PM
Lunch

1:30 - 2:15 PM
Overview of Current Malpractice
Climate
— *Aaron Jacobson, Cleveland*

2:15 - 2:45 PM
Discussion with comments by Dr.
Dunsker

1:30 - 2:45 PM
Moderators:
— *Stewart B. Dunsker, M.D.,*
Cincinnati
— *Russell W. Hardy Jr., M.D.,*
Cleveland Clinic, Cleveland

2:45 - 3:00 PM
Break

3:15 - 4:15 PM
Member Papers

3:00 - 4:00 PM
Moderators:

continued on page 288



In the treatment of insomnia

Good mornings start with restful nights.

Dalmane (*flurazepam HCl/Roche*)
patients fall asleep faster,
sleep longer and seldom awaken
with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.¹ In a double-blind crossover study of

42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam HCl/Roche) compared to placebo nights.² This difference was highly significant ($p < 0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.³

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.⁴ The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.⁵⁻⁸ Since the risk of oversedation, dizziness, confu-



sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.¹ Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.^{9,10} However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.¹¹ When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 3. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 4. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Meyer JA, Kurland KZ: *Milit Med* 138:471-474, Aug 1973. 6. Fetter HL, Gibbons B: *Med Times* 101(8):130-135, Aug 1973. 7. Jacobson A et al: *Psychophysiology* 7:345, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 1978. 10. Kales A et al: *JAMA* 241:1692-1695, Apr 1979. 11. Monti JM: *Methods Find Exp Clin Pharmacol* 3(5):303-326, 1981.



For efficacy from the beginning
to the end of therapy

Dalmane®
flurazepam HCl/Roche
15-mg/30-mg capsules



stands apart

Dalmane[®]

flurazepam HCl/Roche
15-mg/30-mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

— Russell W. Hardy Jr., M.D.,
— Carole A. Miller, M.D., Ohio
State University Hospital,
Columbus

— Robert A. Bruce, Jr., M.D.,
Assistant Professor, Ohio State
University, Columbus

OPHTHALMOLOGY

CME Hours:
3½ Category I

Date:
Tuesday, May 17

Place:
Delaware A & B, Ohio Center

Time:
1:00 PM to 5:00 PM

Sponsor:
OSMA Section on Ophthalmology
and the Ohio Ophthalmological
Society

Topic:
Lasers in Ophthalmology

Schedule:
1:00 - 1:10 PM
Welcome
— Frederick H. Davidorf, M.D.,
Presiding Officer, Columbus

1:10 - 1:25 PM
The Laser: How It Works
— Hugh Beckman, M.D., Detroit,
Michigan

1:30 - 1:45 PM
The Argon Laser
— Lawrence Singerman, M.D.,
Cleveland

1:50 - 2:05 PM
The Krypton Laser
— Lawrence Yannuzzi, M.D., New
York, N.Y.

2:05 - 2:20 PM
Break

2:20 - 2:35 PM
The CO₂ Laser
— Hugh Beckman, M.D.

2:40 - 2:55 PM
The Tunable Dye Laser

3:00 - 3:15 PM
The Ruby Laser
— Hugh Beckman, M.D.,

3:20 - 3:35 PM
The Neodymium/YAG Laser
— Richard H. Keates, M.D., Ohio
State University, Columbus

3:35 - 4:00 PM
Break

4:00 - 5:00 PM
Round Table Discussion
— Drs. Beckman, L'Esperance,
Yannuzzi, Bruce and Keates

OTOLARYNGOLOGY

CME Hours:
7 Category I

Date:
Monday, May 16

Place:
Delaware D (meeting) Delaware C
(lunch), Ohio Center

Time:
8:00 AM to 5:30 PM, 12 Noon Lunch

Sponsor:
OSMA Section on Otolaryngology
and The Ohio Society of
Otolaryngology

Topic:
The Facial Nerve

Schedule:
8:00 AM
Welcoming Remarks
— L. T. Wagenbrenner, M.D.,
President, Ohio Society of
Otolaryngology and Chairman,
OSMA Section on
Otolaryngology, Columbus

8:05 AM
Introduction of Program and
Speakers
— Robert A. Goldenberg, M.D.,
Program Chairman, Ohio Society



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of Otolaryngology and OSMA
Section on Otolaryngology,
Dayton

8:10 AM

Introduction: Etiology of Facial
Paralysis

— *Michael E. Glasscock III, M.D.*,
Nashville, Tennessee

The Basics:

8:15 AM

Anatomy and Physiology of the
Facial Nerve

— *Gordon B. Hughes, M.D.*,
Cleveland Clinic, Cleveland

Pathophysiology of Facial
Paralysis

— *Gordon B. Hughes, M.D.*

Diagnosis — The Neurologic
Evaluation:

8:45 AM

History and Physical Examination
Including Topographic Studies:
Audiometric, Vestibular and
X-Ray Studies

— *Michael E. Glasscock III, M.D.*,

9:15 AM

Prognostic Studies: Salivary Flow
Studies, Nerve Excitability
Testing, Electroneuronography

— *Gordon B. Hughes, M.D.*,

9:45 AM

Coffee Break

Treatment of Specific Facial Nerve
Lesions:

10:00 AM

Tumors Associated with Facial
Nerve Paralysis

— *Michael E. Glasscock III, M.D.*,

10:15 AM

Infection and Cholesteatoma

— *James A. Crabtree, M.D.*, Los
Angeles, California, Clinical
Professor of Otolaryngology,
University of Southern California

10:45 AM

Trauma: Head Injury, Iatrogenic

— *Michael E. Glasscock III, M.D.*,

11:15 AM

Idiopathic Facial Paralysis:
Medical Therapy, Surgical
Intervention, Middle Ear and
Mastoid

— *James A. Crabtree, M.D.*,

11:45 AM

Surgical Intervention, Middle
Fossa

— *Michael E. Glasscock III, M.D.*,

12:00 Noon

Lunch

Guest Speaker: *Elbert R. Nester,*
Esq., L.P.A., Columbus

Topic: "Tax Strategies"

Ohio Society of Otolaryngology
Business Meeting and Election of
Officers

Management of the Paralyzed Face:

2:00 PM

Rehabilitation of the Paralyzed
Face: Grafts

— *James A. Crabtree, M.D.*,

VII - XII Anastomosis

— *Michael E. Glasscock III, M.D.*,

Neuromuscular Pedicle

— *Harvey M. Tucker, M.D.*,
Cleveland

Cleveland Clinic Foundation

Cosmetic Surgery of the Sagging
Face

— *Daniel C. Baker, M.D.*, New
York City, New York

3:00 PM

Hemifacial Spasm

— *James A. Crabtree, M.D.*

3:15 PM

Management of the Facial Nerve
in Head and Neck Oncology

— *Daniel C. Baker, M.D.*,

3:45 PM

Coffee Break

4:00 PM

Panel Discussion of Case
Histories

Moderator — *Michael E. Glasscock*
III, M.D.,

Panelists — *James A. Crabtree,*
M.D.; *Daniel C. Baker, M.D.*;
Gordon B. Hughes, M.D.; *Harvey*
M. Tucker, M.D.

5:00 PM

Discussion - Questions and Answers

5:30 PM

Adjournment

PATHOLOGY

CME Hours:

5 Category I

Date:

Tuesday, May 17

Place:

Union A, Ohio Center (meeting)
Delaware A, Ohio Center (luncheon)

Time:

9:00 AM to 4:30 PM

Sponsor:

OSMA Section on Pathology and the
Ohio Society of Pathologists

Schedule:

Microbiology and Parasitology

— *Joseph F. Meara, M.D.*, Columbus,
Presiding

9:00 - 10:30 AM

Scientific Program

10:30 - 11:30 AM

Legislative Update

— *D. Brent Mulgrew, Esq.*,
Columbus, OSMA Staff Counsel

11:30 AM - 12:00 Noon

Business Meeting

12:00 Noon - 1:30 PM

Awards Luncheon

1:30 - 4:30 PM

Parasitology Slide Seminar

— Presented by *Yizid Gutierrez,*
M.D., Institute of Pathology, Case
Western Reserve University
School of Medicine, Cleveland

PHYSICAL MEDICINE & REHABILITATION

CME Hours:
3½ Category I

Date:
Tuesday, May 17

Place:
Marion Room, Ohio Center

Time:
1:30 PM to 5:00 PM

Sponsor:
OSMA Section on Physical Medicine
and Ohio Society of Physical
Medicine and Rehabilitation

Presiding Officer:
Claire V. Wolfe, M.D., Columbus,
President, Ohio Society of Physical
Medicine and Rehabilitation

Schedule:
11:30 AM - 1:00 PM
Luncheon, Champaign Room

1:30 - 3:00 PM
Evoked Potentials, the Nitty-
Gritty
— *Ernest Baran, M.D.*, Lafayette
Hills, Pennsylvania (A session
discussing the basics of visual,
auditory and somatic indications,
and interpretations. There will
also be a practical session
demonstrating technique for each
evoked potential.)

3:00 - 3:15 PM
Coffee Break

3:15 - 5:00 PM
Practical Session
— *Dr. Baran*

6:10 PM
Cocktails

Dinner, Poolside Barbeque
Stouffer's Dublin Hotel
600 Metro Place North
Dublin

PLASTIC SURGERY

CME Hours:
3 Category I

Date:
Wednesday, May 18

Place:
Union B, Ohio Center

Time:
8:30 AM to 12:30 PM

Sponsor:
OSMA Section on Plastic Surgery

Schedule:
8:30 - 9:30 AM
Cephalometric-Skeletal and Soft
Tissue Relationships of the Face
— *Karl Musgrave, D.D.S., M.S.*,
Columbus

9:30 - 9:45 AM
Break

9:45 - 10:45 AM
The Maxilla and Its Relationship
to Orthognathic Jaw Deformities
— *James W. Ferraro, D.D.S., M.D.*,
Columbus

10:45 - 11:45 AM
The Mandible and Related
Orthognathic Problems
— *Allan Sandel, M.D.*, Akron

11:45 AM
Questions and Answers

12:30 PM
Luncheon
Knox Room, Ohio Center

PSYCHIATRY

CME Hours:
6 Category I

Date:
Monday, May 16

Place:
Delaware A & B, Ohio Center

Time:
8:30 AM to 5:30 PM

Sponsor:
Ohio Psychiatric Association and the
OSU Sleep Disorders Evaluation
Center

Topic:
Sleep Disorders Medicine: A
Comprehensive Update for the
Practicing Physician

Schedule:
8:00 - 8:30 AM
Registration

8:30 - 9:20 AM
Overview of Sleep and the Sleep
Disorders Nosology
— *Howard P. Roffwarg, M.D.*,
Professor of Psychiatry, Director,
Sleep Disorders Center,
Southwestern Medical School,
Dallas, Texas

9:20 - 9:55 AM
Sleep Disorders in
Neuropsychiatric Patients
— *Charles F. Reynolds III, M.D.*,
Associate Professor of Psychiatry
& Neurology, Medical Director,
Sleep Evaluation Center, Western
Psychiatric Institute, Pittsburgh,
Pennsylvania

9:55 - 10:15 AM
Coffee Break

10:15 - 11:00 AM
Diagnosis and Treatment of the
Insomnias
— *Thomas Roth, Ph.D.*, Director,
Sleep Disorders and Research
Center, Henry Ford Hospital,
Detroit, Michigan

11:00 - 11:50 AM
Sleep Apnea Syndromes:

Medical Management
— *Helmut S. Schmidt, M.D.*,
Associate Professor of Psychiatry,
Director, Division of Sleep
Medicine, Ohio State University,
Columbus

Surgical Management
— *David E. Schuller, M.D.*,
Associate Professor of
Otolaryngology, Director, Head &

Neck Oncology Program O.S.U.
Comprehensive Cancer Center,
Columbus

11:50 AM - 12:15 PM

Open discussion - Panel and
Audience

12:15 PM

Lunch
Regency Ballroom N, Ohio Center

2:00 - 2:35 PM

Sleep and Aging
— *Charles F. Reynolds III, M.D.*,

2:35 - 3:10 PM

Sleep Disorders in Children
— *Richard A. Ferber, M.D.*,
Director, Sleep Disorders Clinic,
Children's Hospital Medical
Center, Boston, Massachusetts

3:10 - 3:30 PM

Open Discussion - Panel and
Audience

3:30 - 3:45 PM

Coffee Break

3:45 - 4:15 PM

Use of Hypnotics in Clinical
Medicine
— *Thomas Roth, Ph.D.*,

4:15 - 5:00 PM

Narcolepsy and Other
hypersomnias: Diagnosis and
Treatment Approaches
— *Martin B. Scharf, Ph.D.*,
Associate Professor of Psychiatry,
Director, Sleep Disorders Center,
University of Cincinnati Hospital

5:00 - 5:30 PM

Open Discussion - Panel and
Audience

RHEUMATOLOGY

CME Hours:

4 Category I

Date:

Monday, May 16

Place:

Madison Room, Ohio Center

Time:

1:30 PM to 5:30 PM

Sponsor:

OSMA Section on Rheumatology
and the Ohio Rheumatism Society

Program Chairman:

Robert I. Finkel, M.D., President
Ohio Rheumatism Society

Schedule:

12:00 Noon - 1:20 PM

Luncheon (*members only*)
Fayette Room, Ohio Center

1:30 - 2:20 PM

Purinogenic Immune Deficiency
States — The Purine Connection
— *Irving H. Fox, M.D.*, Dept. of
Internal Medicine, University of
Michigan, Ann Arbor, Michigan

2:20 - 2:30 PM

Discussion & Question Period

2:30 - 2:50 PM

Fibrositis: Recognition and
Management
— *Allan B. Kirsner, M.D.*, Toledo
Clinic, Inc., Toledo
Followed by Discussion &
Question Period

2:50 - 3:00 PM

Refreshment Break

3:00 - 3:45 PM

Remittive Therapy in Rheumatoid
Arthritis: Chrysotherapy and
Penicillamine
— *Marvin H. Thomas, M.D.*,
Columbus Medical Center,
Columbus

3:45 - 3:55 PM

Discussion & Question Period

3:55 - 4:40 PM

Systemic Lupus Erythematosus
and SLE Variants in Childhood
— *Robert Rennebohn, M.D.*,
Department of Internal Medicine,
University of Cincinnati,
Cincinnati

4:40 - 4:50 PM

Discussion & Question Period

5:00 - 5:20 PM

Benign Hypermobility Syndrome
— *Dr. Kirsner*

5:20 - 5:30 PM

Discussion & Question Period

SPORTS MEDICINE

CME Hours:

6 Category I

Registration Fee:
\$15.00

Date:

Monday, May 16

Place:

Union A & B; luncheon Union D &
E, Ohio Center

Time:

8:30 AM - 4:00 PM; luncheon 12
Noon

Sponsor:

OSMA Section on Sports Medicine

Topic:

Sports Medicine for the Coach - As
Well As Physician

Schedule:

8:00 AM
Registration (coffee)

8:30 AM

Welcome, Opening
Announcements
— *Ronald C. Van Buren, M.D.*,
Program Moderator & Chairman,
Committee on Sports Medicine,
Academy of Medicine of
Columbus & Franklin County,
Columbus

8:40 AM

Sensible Weight Control for
Athletes
— *James T. Violet, D.O.*, Co-
Chairman, Subcommittee on
Playoff Coverage, Joint Advisory
Committee on Sports Medicine,
Canton

— *Richard Strauss, M.D.*, The
Ohio State University, Columbus

9:30 AM

Field Decisions for the Coach
Who Doubles as Trainer

— *Ted Georgeff, A.T.C.*,
Subcommittee on Education, Joint
Advisory Committee on Sports
Medicine and Head Athletic
Trainer, Capital University,
Columbus

— *Bob Miller*, Head Football &
Basketball Coach, Groveport-
Madison High School, Groveport

10:20 AM

Heads Up — Prevention &
Prompt Action for Possible
Injuries of the Brain, Spinal Cord
& Peripheral Nerves
— *James E. Barnes, M.D.*,
President, Academy of Medicine
of Columbus & Franklin County,
Columbus

11:10 AM

Questions & Answers - Panel of
Morning Speakers
Moderator - *Robert J. Murphy*,
M.D., Chairman, Subcommittee
on Education, Joint Advisory
Committee on Sports Medicine,
Columbus

11:40 AM

Lunch

1:00 PM

Four afternoon workshops.
Registrants divided into four
groups — rotating every 45
minutes.

(1) Drugs - Legitimate and
Otherwise

— *Robert J. Murphy, M.D.*

— *Michael J. Vuksta, M.D.*, Vice-
Chairman, Joint Advisory
Committee on Sports Medicine,
Youngstown

(2) Sensible Nutrition for the
Young Athlete

— *Jane Buch*, Home Economics
Teacher, Chippewa High School,
Doylestown

— *Lorri Porcello, Ph.D.*, Medical
Nutrition Education, Ross
Laboratories, Columbus

(3) Taping & Other Pre-Game
Safeguards For the Coach Who
Doubles As Trainer

— *Ron Walter, A.T.C.*, Member,
Subcommittee on Playoff
Coverage, Joint Advisory
Committee on Sports Medicine,
Upper Arlington High School,
Upper Arlington

— *Ted Georgeff, A.T.C.*

— *David Shon, A.T.C.*,
Subcommittee on Legislation,
Joint Advisory Committee on
Sports Medicine and Head
Athletic Trainer, Wright State
University, Dayton

— *Kenneth C. Wolfert, A.T.C.*,
Member, Subcommittee on
Education, Joint Advisory
Committee on Sports Medicine
and Director, SW Ohio Sports
Medicine Center, Hamilton

(4) Chronic Health Problems - To
Play or Not to Play

— *Delphis Richardson, M.D.*, Co-
Chairman, Subcommittee on
Playoff Coverage, Joint Advisory
Committee on Sports Medicine,
Columbus

— *Ronald C. Van Buren, M.D.*

4:00 PM

Adjourn

OHIO COMMITTEE ON TRAUMA A.C.S.

CME Hours:

3 Category I

Date:

Monday, May 16

Place:

Union C, Ohio Center

Time:

9:00 AM to 12:00 Noon

Sponsor:

OSMA Section on Trauma, A.C.S.

Panel Discussion:

Should Ambulances Fly?

Panel discussion will include a
thorough discussion of the need for,
the advantages of, or the
disadvantages of helicopter

transportation for critically ill and
injured patients.

Also to be on display: MAST
Helicopter from Lorain, Ohio and
Life Flight from Grant Hospital,
Columbus, Ohio.

Presiding Officer:

Richard B. Fratiante, M.D.,
Chairman, Ohio Committee on
Trauma, A.C.S., Cleveland

Panel Moderator:

— *Kathleen Musser, M.D.*, Columbus

Panel Participants:

— *Mr. Howard M. Collett*, Director of
Aviation/Hospital Consultants,
Orem, Utah

— *Alasdair Conn, M.D.*, Director of
EMS Systems, Maryland Institute of
Emergency Medical Services,
Baltimore, Maryland

— *Frank E. Foss, M.D.*, Director of
Life Flight, St. Vincent Hospital,
Toledo

— *David E. Lehtinen, M.D.*,
Neurosurgeon, Coordinator of
MAST Program, Lakewood Hospital,
Lakewood

UROLOGY

CME Hours:

3 Category I

Date:

Monday, May 16

Place:

Champaign Room, Ohio Center

Time:

9:00 AM to 3:00 PM

Sponsor:

Ohio Urological Society

Topic:

Endourology: Urological and
Radiological Approaches

Schedule:

continued on page 313

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Thallium-201 perfusion scan showing left ventricle of patient with angina.



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INDERAL, used early, reduces myocardial oxygen demand and protects against ischemia. INDERAL slows heart rate, decreases contractility, and lowers elevated blood pressure. Use INDERAL early in the treatment of angina to prevent ischemia-induced pains and to protect the heart against coexisting arrhythmias... and their consequences.



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CARDIOVASCULAR PROTECTION

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FOR ANGINA.



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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
Inderal[®] (propranolol hydrochloride)

BEFORE USING Inderal (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS,

EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. **Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10", contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).
—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20", contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).
—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40", contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).
—Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60", contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-99).
—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80", contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).
The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).
INJECTABLE

—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).
Store at room temperature (approximately 25° C).

Ayerst.

AYERST LABORATORIES
New York, N.Y. 10017

8225/483

The OSMA's Art and Culture Committee's

Theatre Party

Saturday, May 14
8:00 p.m.

Players Theatre presents

MORNING'S AT SEVEN

Produced with success in New York, this play tells the small-town intrigue of dear hearts and gentle people during a time when life was simpler. Two of the Gibbs sisters have lived next door to each other most of their lives, and each knows intimately the other's life.

Join us at the theatre and watch how cleverly Myrtle schemes to catch Homer.

Players Theatre of Columbus, recognized as one this country's finest community theatres, is dedicated to producing a wide range of quality drama.

Buses depart at 7:30 P.M. from the Hyatt Regency.

Buses will be provided to the theatre from the Hyatt and return back to the Hyatt.

An after-theatre party in the Marion and Morrow Rooms at the Hyatt will follow immediately upon return.

(see next page for reservation form)

OMPAC Luncheon

Saturday, May 14

Regency Ballroom/Regency North Foyer
Hyatt Regency at the Ohio Center
Columbus, Ohio



*John McLaughlin
Host, McLaughlin Group (TV)
Executive Editor
The National Review*

Reception: 11:30 AM

Luncheon: 12 Noon

This year's speaker is John McLaughlin. As Chief Washington Editor of William Buckley's National Review, McLaughlin's articles focus on a variety of domestic and international subjects. His opinions are based on firsthand, on-the-spot information gathered in the United States and abroad from hundreds of thousands of miles of travel during the past ten years.

Formerly a Deputy Special Assistant, McLaughlin served President Nixon and President Ford for three and one half years as a speech writer, fact finder, presidential spokesman and counselor on domestic matters, public opinion and international humanitarian affairs.

Number of Tickets

OMPAC Luncheon _____ \$15.00 per person \$ _____

Players Theatre _____ \$30.00 per person \$ _____

Morning's at seven
with After-Theatre Party

After-Theatre Party *Only* _____ \$18.00 per person \$ _____

Make Check Payable to:
Ohio State Medical Association

Name _____

Street _____

City _____ Zip _____

Telephone: Area Code () Number _____

Mail Ticket Order & Check to:
Dept. of Education & Meeting Management
Ohio State Medical Association
600 S. High Street
Columbus, Ohio 43215

The Medical Volunteer: Growing to Meet the Challenge

43rd Annual Convention of the Ohio State Medical Association Auxiliary

May 10-12
The Hyatt Regency Columbus

TUESDAY, MAY 10

10AM - 6PM	Registration	Delaware A and B Foyer	11AM - 12:30PM	Voting	Delaware A and B Foyer
11AM - 10PM	County Walk Setup, Hospitality Room	Morrow Room	12 Noon	Gavel Club Luncheon	Board Room 2
12 Noon	State Board Luncheon	Madison Room	12:30 - 3:30PM	Shopping Expedition - Lane Avenue (Meet bus at North Dropoff Ramp of Ohio Center)	
1:30-3:30PM	State Board Meeting	Madison Room	4:30 - 5:30PM	Orientation for Presidents-Elect and New State Officers	Delaware A Room
3:30 - 4PM	Bylaws Revision Hearing	Madison Room	6:45 - 7:30PM	Presidential Reception	Fairfield Room
4 - 4:30PM	Resolutions Committee Meeting	Madison Room	7:30PM	Dinner and Entertainment	Fairfield Room
6:30 - 7:30PM	Social Hour	Fairfield Room			
7:30PM	Dinner - Style Show "With You In Mind"	Fairfield Room			

WEDNESDAY, MAY 11

THURSDAY, MAY 12

7:45 - 8:15AM	Complimentary Continental Breakfast	Delaware A and B Foyer	7:45 - 8:15AM	Complimentary Continental Breakfast	Delaware A and B Foyer
8AM - 6PM	Registration	Delaware A and B Foyer	8-11AM	Registration	Delaware A and B Foyer
8AM - 10PM	County Walk, Hospitality	Morrow Room	8AM - 3PM	County Walk, Hospitality	Morrow Room
8:30 - 11AM	House of Delegates First Business Session	Delaware A and B Rooms	8:30-11AM	House of Delegates Second Business Session	Delaware A and B Rooms
			12 Noon	Installation Luncheon and Reception for Mrs. John Brown (Stella)	Fairfield Room
			11AM - 3PM	County Walk Exhibit Tear Down	Morrow Room

1983 OSMA Auxiliary Convention Registration Form
To make meal reservations and to register for activities,
please complete this form and mail by April 25, 1983.

Send to: Mrs. J. B. Dingle
2666 Sandover Road
Columbus, Ohio 43220.

Make checks payable to: OSMA Auxiliary Convention Fund

Tuesday, May 10, 1983

Dinner - Style Show (With You In Mind)@ \$19/ticket

Wednesday, May 11, 1983

Shopping Transportation@ \$ 5/ticket

Dinner - Entertainment@ \$19/ticket

Thursday, May 12, 1983

Installation Luncheon@ \$ 9.50/ticket

TOTAL enclosed \$_____

PLEASE NOTE: No reservations will be accepted unless accompanied by a check!

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

Hotel staying at while in Columbus _____

**THE
MEDICAL PROTECTIVE COMPANY**

FORT WAYNE, INDIANA



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Suite 106, 23360 Chagrin Boulevard
Beachwood 44122,
(216) 464-9950

Southeast Office
J. E. HANSEL
1989 West 5th Ave.
Columbus 43212
(614) 486-3939

Northwest Office
R. E. STALLER
1011 Sandusky St., Suite H, P.O. Box 331
Perrysburg 43551,
(419) 874-8080

County Society Officers, Executive Directors and Meeting Dates

1 st District

Councilor: *John E. Albers, M.D.* 2350 Auburn Ave., Cincinnati 45219.

ADAMS: Gary Greenlee, M.D., President, 33 E. Second St., Manchester 45144; David E. Pixley, M.D., Secretary-Treasurer, 154 E. Elliott Ave., Peebles 45660. Second Tuesday.

BROWN: Leslie Hampton, M.D., President, Box 5, Sardinia 45171; Walter Ferris, M.D., Secretary-Treasurer, 614 S. High St., Mt. Orab 45154. Third Tuesday, every other month.

BUTLER: John L. Ritan, M.D., President, Middletown Hospital, Middletown 45042; Jack S. Sizer, M.D., Secretary-Treasurer, 2403 Central Ave., Middletown 45042; Mrs. Joan Williams, Executive Secretary, 111 Buckeye St., P.O. Box 3216, Hamilton 45013, 513/893-1410. Fourth Wednesday, January - May, October, November.

CLERMONT: George T. Pack, M.D., President, 602 Lila Ave., Milford 45150; William Blake Selnick, D.O., Secretary-Treasurer, Second & E. Loveland Aves., Loveland 45140. Second Tuesday.

CLINTON: Mary R. Boyd, M.D., President, Clinton County Health Dept., Court House, Wilmington 45177; Janet Gick Matrk, M.D., Secretary-Treasurer, 222 W. Main St., Wilmington 45177; Marilyn S. Walker, Executive Secretary, 119E State Route 122, Lebanon 45036, 513/382-6611 (lab). Fourth Tuesday except July and December.

HAMILTON: George C. Hale, Sr., M.D., President, 437 Melish Ave., Cincinnati 45229; John L. Thinnies, M.D., Secretary, 9030 Montgomery Road, Cincinnati 45242; William J. Galligan, Executive Director, 320 Broadway, Cincinnati 45202, 513/421-7010. Second Tuesday.

HIGHLAND: No active county medical society.

WARREN: George Rourke, M.D., President, 445 Hoffman Ave., Lebanon 45036; Gary Hayes, M.D., Secretary, 1004 Oregonia Road, Lebanon 45036. Second Tuesday.

2 nd District

Councilor: *Herman I. Abramowitz, M.D.*, 226 Troy St., Dayton 45404.

CHAMPAIGN: James B. Hall, M.D., President, 900 Scioto St., Urbana 43078; J. Steven Polsley, M.D., Secretary-Treasurer, 160 Eastview Dr., Urbana 43078. Second Wednesday.

CLARK: David D. Smith, M.D., President, 200 S. Douglas Ave., Springfield 45505; Paul Andorfer, M.D., Secretary, 2800 Rockford Dr., Springfield 45503; Mrs. Colleen Buscemi, Executive Secretary, 34 W. High St., Room 710, Springfield 45502, 513/324-8618. Third Monday.

DARKE: Margaret J. Hensel, M.D., President, Arcanum Medical Center, Arcanum 45304; Stephen Brewer, M.D., Secretary, 552 S. West St., Versailles

45380. Third Tuesday.

GREENE: Manoj Desai, M.D., President, 717 W. Xenia Dr., Fairborn 45324; S. S. Patil, M.D., Secretary-Treasurer, 1160 N. Monroe Dr., Xenia 45385; Mrs. Judy Khoii, Executive Secretary, 649 Monroe Dr., Xenia 45385, 513/372-8745 (home). Four times a year.

***MIAMI:** A. Robert Davies, M.D., President, 530 Crescent Dr., Troy 45373; Ramen Das, M.D., Secretary, 624 Park Ave., Piqua 45356. First Tuesday.

MONTGOMERY: William J. Marshall, M.D., President, 2600 Far Hills Ave., Dayton 45419; John K. Wiley, M.D., Secretary, 616 Enid Ave., Kettering 45429; Richard G. Tapia, Executive Director, 40 S. Perry St., Suite 100, Dayton 45402, 513/223-1431. Second Thursday except July and August.

PREBLE: John D. Darrow, M.D., President and Secretary, 228 N. Barron St., Eaton 45320.

SHELBY: George J. Schroer, M.D., President, 1731 Letitia Dr., Sidney 45365; Yung Koh, M.D., Secretary-Treasurer, 915 W. Michigan St., Sidney 45365. Second Tuesday.

3 rd District

Councilor: *Thomas R. Leech, M.D.* 1700 Market St., Lima 45805.

***ALLEN:** Lawrence L. Young, M.D., President, 825 W. Market St., Lima 45805; Roger L. Terry, M.D., Secretary-Treasurer, Orthopaedic Surgeons of Lima, 1220 E. Elm St., Suite 110, Lima 45805; Will Wolf, Executive Secretary, P.O. Box 1647, Lima 45802, 419/228-3335. Third Tuesday, Sept. - May.

AUGLAIZE: Herbert Wolfe, M.D., President, 405 S. Main St., Box 238, New Knoxville 45871; Robert P. Gill, M.D., Secretary-Treasurer, 4 Eagle Dr., Minster 45865. First Thursday, Jan., March, May, Sept. and Nov.

CRAWFORD: Jack W. Arnold, M.D., President, 241 E. Rensselaer St., Bucyrus 44820; Donald R. Wenner, M.D., Secretary-Treasurer, 140 Hill St., Bucyrus 44820. When called.

HANCOCK: William Elderbrock, M.D., President, 1920 S. Main St., Findlay 45840; Irineo P. Echavarre, M.D., Secretary, 206 W. Lima St. Findlay 45840. Third Tuesday.

HARDIN: Jose Castrillo, M.D., President, 110 N. Cherry St., Kenton 43326; Kamchai Ratanachinakorn, M.D., Secretary-Treasurer, 9 Lincoln Ct., Kenton 43326. Second Tuesday.

LOGAN: Donald R. Ebersole, M.D., President, 1008 N. Main St., Bellefontaine 43311; Evan W. Dixon, M.D., Secretary-Treasurer, P.O. Box 610, Bellefontaine 43311.

***MARION:** Narayanan Ponnusamy, M.D., President, 300 Executive Dr., Marion 43302; Vernon Nichols, M.D., Secretary-Treasurer, 318 E. Center St., Marion 43302. First Tuesday except June - September.

MERCER: Robert W. Albers, M.D., President, 906 N. Cedar St., Coldwater

45828; George H. McIlroy, M.D., Secretary-Treasurer, 123 E. Fayette St., Celina 45822. Third Thursday except June, July and August.

SENECA: Pramuan Thirasilpa, M.D., President, 948 Ebersole Dr., Fostoria 44830; Rosario D. Bello, M.D., Secretary-Treasurer, 1230 Roosevelt Dr., Fostoria 44830. Third Tuesday except July, August and December.

VAN WERT: Robert C. Adams, M.D., President, Medical Arts Building, 140 Fox Road, Van Wert 45891; Wilmer Iler, M.D., Secretary-Treasurer, Medical Arts Building, 140 Fox Road, Van Wert 45891. First Tuesday.

WYANDOT: Konstantin K. Solacoff, M.D., President, 777 N. Sandusky Ave., Upper Sandusky 43351; Thomas C. Thornton, M.D., Secretary-Treasurer, 110 S. Patterson Ave., Carey 43316; Gloria Orians, A.R.T., Executive Secretary, Wyandot Memorial Hospital, 885 N. Sandusky Ave., Upper Sandusky 43351, 419/294-1941, ext 32. Second Tuesday.

4 th District

Councilor: *Benjamin H. Reed, M.D.* 730 Burr Road, Wauseon 43567.

DEFIANCE: Jack Kane, M.D., President, P.O. Box 70, Defiance 43512; Nilo V. Gomez, M.D., Secretary-Treasurer, 1400 E. Second St., Defiance 43512. Twice yearly.

FULTON: David A. Thompson, M.D., President, 405 E. Lutz Road, Archbold 43502; Estela T. Miquiabas, M.D., Secretary-Treasurer, 725 S. Shoop Ave., Wauseon 43567. Saturday, quarterly.

HENRY: William J. Stough, M.D., President, 515 Avon Place, Napoleon 43545; A. A. Lauengco, M.D., Secretary-Treasurer, Belton & Marion Sts., Hamler 43524. When called.

LUCAS: James G. Diller, M.D., President, 4235 Secor Road, Toledo 43623; Lily N. Sim, M.D., Secretary, 3900 Sunforest Ct., Toledo 43623; Lee F. Wealton, Executive Director, 4428 Secor Road, Toledo 43623, 419/473-3200. Fourth Tuesday.

OTTAWA: John F. Bodie, M.D., President, 1130 Lee Ave., Port Clinton 43452; Barry R. Cover, M.D., Secretary-Treasurer, P.O. Box 579, Port Clinton 43452. Second Thursday, fall; second Friday, otherwise.

PAULDING: Don K. Snyder, M.D., President, Route 2, Box 1271, Paulding 45879; William Max Miller, M.D., Secretary-Treasurer, 602 Emerald Road, Paulding 45879. Third Monday.

PUTNAM: Earl Dewitt, M.D., President, 240 E. Sycamore St., Columbus Grove 45830; Charles Kidd, M.D., Secretary-Treasurer, Box 256, Kalida 45853. First Tuesday.

SANDUSKY: Samuel R. Lowery, M.D., President, 1236 Napoleon St., Fremont 43420; John L. Zimmerman, M.D., Secretary-Treasurer, Memorial Hospital, Fremont 43420; Mrs. Patsy J. Reed, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420,

continued on page 303

ANNOUNCING...

The Deaconess Hospital Center for Reconstructive Hip and Knee Surgery

■ *It's an answer to a regional need.*

The Deaconess Hospital of Cincinnati is pleased to offer a new regional service for patients undergoing total joint replacement. Initiated in November, 1982, by the Hospital in cooperation with its Medical Staff, a comprehensive program has been developed by the orthopedic surgeons of the staff in conjunction with internists, rheumatologists and other support personnel.

■ *The program includes:*

1. Pre-operative evaluation and teaching.
2. A modern, versatile, and completely equipped operative suite that allows maximum flexibility on the part of the surgeon.
3. Careful post-operative monitoring.
4. Coordinated discharge planning.
5. Inclusion of all patients into a computerized data base to facilitate clinical research.

■ *Complicated cases are welcome.*

The Orthopedic Staff is highly experienced in all aspects of joint replacement surgery and welcomes complicated cases, including those patients who have had previous surgery.

Any physician can register his patient in the program by contacting The Deaconess Hospital Center for Reconstructive Hip and Knee Surgery.



dh THE DEACONESS HOSPITAL
CENTER FOR RECONSTRUCTIVE HIP AND KNEE SURGERY

311 Straight Street • Cincinnati, OH 45219 559-2597 (local)
1-800-582-2222 (toll free, Ohio) 1-800-543-3344 (toll free, out-of-state)

419/332-7321. Last Thursday of month.

WILLIAMS: Clarence Bell, M.D., President, 935 Snyder Ave., Montpelier 43543; Richard L. Hess, M.D., Secretary-Treasurer, 442 W. High St., Bryan 43506; Mrs. Rebecca Cape, Executive Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506, 419/636-4517. Third Tuesday, Jan., Mar., May, Sept., Nov.

WOOD: Said Shehata, M.D., President, 960 W. Wooster St., Bowling Green 43402; William Feeman, M.D., Secretary-Treasurer, 640 S. Wintergarden Road, Bowling Green 43402. Third Thursday.

5 th District

Councilor: *Edward G. Kilroy, M.D.* 18099 Lorain Road, Cleveland 44111.

ASHTABULA: Syed A. Hussaini, M.D., President, 830 W. Main, Geneva 44041; N. Rehmatullah, M.D., Secretary-Treasurer, 158 W. Main Road, Conneaut 44030; Miss Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, 216/998-3111. Second Tuesday, Feb., Apr., Sept., Nov.

***CUYAHOGA:** Ray W. Gifford, Jr., M.D., President, 9500 Euclid Ave., Cleveland 44106; Hermann Menges, Jr., M.D., Secretary-Treasurer, University Suburban Health Center, 1611 S. Green Road, Cleveland 44121; Robert A. Lang, Ph.D., Executive Director, 11001 Cedar Road, 6th Floor, Cleveland 44106, 216/229-2200.

GEAUGA: Robert Evans, D.O., President, 15465 Durkee Road, Middlefield 44062; Mohammad Ansari, M.D., Secretary-Treasurer, 13221 Ravenna Road, Chardon 44024; Mrs. Margaret Pace, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, 216/286-6131. Second Thursday, Jan., Apr., Sept., Nov.

LAKE: Ronald E. Posner, M.D., President, 8224 Mentor Ave., Mentor 44060; Quentin Spittler, M.D., Secretary-Treasurer, 8224 Mentor 44060; Mrs. Janice A. Vargo, Executive Secretary, Lake County Memorial Hospital, 71 E. High St., Painesville 44077, 800/GET-WELL. Feb., May, Sept., Nov.

6 th District

Councilor: *J. James Anderson, M.D.* 5204 Mahoning Ave., Suite 103, Youngstown 44515.

COLUMBIANA: Orlando Castro, M.D., President, 326 Windsor Dr., East Liverpool 43920; Hira Rohela, M.D., Secretary-Treasurer, 122 W. Fourth St., East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 163 Park Ave., Salem 44460, 216/337-8859. Third Tuesday except June, July, August and December.

MAHONING: Paul J. Mahar, Jr., M.D., President, 7087 West Blvd., Suite 3, Youngstown 44512; H. S. Wang, M.D., Secretary, 10 Dutton Dr., Youngstown 44502; Robert B. Blake, Executive Director, 1005 Belmont Ave. #245, Youngstown 44504, 216/747-4956. Second Tuesday.

STARK: Andres B. Lao, M.D., President, 214 E. State St., Alliance 44601; Robert T. Spangler, M.D., Secretary-

Treasurer, 1445 Harrison Ave., NW, Canton 44708; Mrs. Nancy Adams, Executive Secretary, 4150 Belden Village St., NW, Canton 44718, 216/492-3333. Second Thursday, October - April.

TRUMBULL: Lewis P. Sarkos, M.D., President, 2400 Niles-Cortland Road, SE, Warren 44484; Englebert Hecker, M.D., Secretary-Treasurer, 9070 Echo Lake Dr., Warren 44484; Mrs. Judy Wallace, Executive Secretary, 280 N. Park Ave., Warren 44481, 216/394-4556. Third Wednesday.

7 th District

Councilor: *H. Judson Reamy, M.D.* 931 Fourth St., NW, New Philadelphia 44463.

BELMONT: Ruben Nepomuceno, M.D., President, 106 Orchard Dr., St. Clairsville 43950; Nermin D. Lavapies, M.D., Secretary-Treasurer, 1220 Hughes Ave., Martins Ferry 43935. Third Thursday, Feb. - Apr., Sept. - Dec.

CARROLL: Carl A. Lincke, M.D., President, 24 Second St., NE, P.O. Box 5, Carrollton 44615; Nan M. Bissell, M.D., Secretary-Treasurer, 450 S. Lisbon St., P.O. Box 338, Carrollton 44615. Third Tuesday.

COSHOCTON: Jerold A. Meyer, M.D., President, 404 S. 15th St., Coshocton 43812; Richard Emmons, M.D., Secretary-Treasurer, 646 Chestnut St., Coshocton 43812. Second Tuesday.

HARRISON: Ajit S. Modi, M.D., President, R.D. #1, Cadiz 43907; Siripurapu R. Prasad, M.D., Secretary-Treasurer, Main St., Box 323, Jewett 43986. Second Tuesday.

JEFFERSON: Dominic Macedonia, M.D., President, 523 N. Fourth St., Steubenville 43952; Narendra K. Patel, M.D., Secretary-Treasurer, Ohio Valley Hospital, 380 Summit Avenue, Steubenville 43952. First Tuesday.

MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793; Jack M. Matheny II, M.D., Secretary-Treasurer, Monroe County Clinic, Old Airport Road, Route 3, Woodsfield 43793. First Wednesday, every fourth month.

TUSCARAWAS: Yogendra Shah, M.D., President, 899 E. Iron Ave., Dover 44622; Daniel J. Clemens, M.D., Secretary-Treasurer, 899 E. Iron Ave., Dover 44622. Second Wednesday.

8 th District

Councilor: *Carl E. Spragg, M.D.*, 71 W. Main St., New Concord 43762.

ATHENS: Larry Dansky, M.D., President, 400 E. State St., Athens 45701; John Cunningham, M.D., Secretary-Treasurer, P.O. Box 708, Athens, 45701. Second Tuesday, Mar., June, Sept., Dec.

FAIRFIELD: Joseph Kirkpatrick, M.D., President, 1500 E. Main St., Lancaster 43130; Stephen Scarbrough, M.D., Secretary-Treasurer, 600 Pleasantville Road, Lancaster 43130. Second Tuesday.

GUERNSEY: A.R. Srikantiah, M.D., President, 9884 Cadiz Road, Cambridge 43725; Ashfaq H. Siddiqui, M.D., Secretary-Treasurer, Vascular Surgery,

Inc., Maple Dr., Cambridge 43725. First Tuesday except July and August.

LICKING: G. Franklin Gabe, M.D., President, 1272 W. Main St., Newark 43055; Mary Beth Hall, M.D., Secretary-Treasurer, 1877 Tamarack Road, Newark 43055; Mrs. Lindsay Freytag, Executive Secretary, 1175 Mt. Vernon Road, Newark 43055; 614/366-2280. Fourth Tuesday except June - Sept.

MORGAN: No active county medical society.

MUSKINGUM: George M. Kopf, M.D., President, 2315 Maple Ave., Zanesville 43701; Vicki Whitacre, M.D., Secretary-Treasurer, 2312 Dunzweiler Dr., Zanesville 43701. First Tuesday except June, July, August.

NOBLE: Frederick M. Cox, President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, M.D., Secretary-Treasurer, P.O. Box 239, Caldwell 43724. First Tuesday.

PERRY: Ralph E. Herendeen, Jr., M.D., President, 203 N. Main St., New Lexington 43764; Stephen A. Ulrich, M.D., Secretary-Treasurer, 203 N. Main St., New Lexington 43764. Four times yearly.

WASHINGTON: Richard D. Hershey, M.D., President, Marietta Memorial Hospital, Marietta 45750; H. L. Krupadev, M.D., Secretary-Treasurer, 736 Kelford Place, Trotwood, 45420. Second Wednesday.

9 th District

Councilor: *A. Burton Payne, M.D.* 411 Center St., Ironton 45638.

GALLIA: John H. Viall, M.D., President, Holzer Clinic, Ltd., P.O. Box 344, Gallipolis 45631; James R. Magnussen, M.D., Secretary-Treasurer, Holzer Clinic, Ltd., P.O. Box 344, Gallipolis 45631. Quarterly.

HOCKING: Roy R. Bontrager, M.D., President, Box 987, Logan 43138; James Hayward, D.O., Secretary-Treasurer, c/o Roy R. Bontrager, M.D., President, Box 987, Logan 43138.

JACKSON: Louis J. Jindra, M.D., President, P.O. Box 316, Oak Hill 45656; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.

LAWRENCE: Portia Canos, M.D., President, P.O. Box 743, Ironton 45638; David A. Pack, M.D., Secretary-Treasurer, 1230 Navajo Trail, Ironton 45638. Fourth Thursday.

MEIGS: Selim Blazewicz, M.D., President, Box 511, Pomeroy 45769; Wilma Mansfield, M.D., Secretary-Treasurer, P.O. Box 351, Pomeroy 45769. When called.

PIKE: Kenneth A. Wilkinson, M.D., President, 435 Pennington Road, Waverly 45690; Janie Hwang, M.D., Secretary-Treasurer, 300 Cherry St., Waverly 45690.

SCIOTO: David B. Hanzel, M.D., President, C.B. 18, Wheelersburg 45694; William T. Esham, M.D., Secretary-Treasurer, 1501 Franklin Ave., Portsmouth 45662; Lowell Thompson, Executive Secretary, P.O. Box 1348, Portsmouth 45662, 614/354-7581. Second Tuesday.

VINTON: No active county medical society.

continued on page 311

Easier claims

handling

Cutting down on forms and reducing time-consuming claims handling are important advantages of the new ADVANCE Plan agreement, now being introduced by Ohio Medical Indemnity Mutual Corp., the Blue Shield Plan headquartered in Worthington. The streamlined claims handling procedures designed into the program can reduce your administrative costs — and ours at OMIM as well. The agreement asks that

you accept as payment-in-full our UCR reimbursement for covered Basic services you perform. In return, as a cooperating ADVANCE Plan physician, you'll benefit from easier claims procedures, including automatic direct payment to you of Blue Shield Basic claims... reduced CRT terminal costs for use of our OPEN automated, paperless claims data entry system... and a direct toll-free line to an inquiry service in our Worthington offices for questions about procedures and claims. For full details, ask your Blue Shield Professional Relations area representative. Easier claims handling. It's one of the advances of the

ADVANCE PLAN

Good business theory,
put into practice



Blue Shield
Ohio Medical Indemnity Mutual Corp.

The 1983 Annual Meeting of the OSMA's Medical Students Section

By Louis Saslaw

Frank Papay, President, called the meeting to order.

Nineteen students, from all six Ohio medical schools, were in attendance.

The following bylaws changes, publicized in the January *OSMAgram* were passed:

RESOLVED, That the OSMA Bylaws be changed, beginning at the OSMA 1984 Annual Meeting, allowing seven student delegates, one from each medical school and the President of the OSMA-MSS, to be seated at the OSMA House of Delegates.

New officers were elected. They are: President, Alan Mong, Ohio State University; Vice-President, David Roer, Wright State University; Secretary, Linda Weber, Ohio State University.

The following students were selected as six delegates to the OSMA House:

Case Western — Bill Pomputius

University of Cincinnati — J. Michael Koch

Medical College of Ohio — J.R. Sarpa

NEOUCOM — Joe Crow

Ohio State University — Not yet selected

Wright State University — Not yet selected

The following resolutions were considered by the Medical Student Section:

Publication and Distribution of Governing Council Research of Financial Aid Resources

RESOLVED, That the Governing Council of the OSMA-MSS assemble pertinent information regarding the financial aid options available to Ohio medical students, and that the Governing Council publish the results of its research of financial aid resources and distribute, as it sees fit, such publication to Ohio medical students. ACTION: The resolution was passed.

Loan Consolidation and Refinancing

RESOLVED, That the OSMA-MSS, through appropriate publications, inform all students in Ohio about the existence of the OPTIONS program, and how the program may help students avoid loan default, and be it further

RESOLVED, that the OSMA-MSS and the OSMA support the concept of loan consolidation, and through its support encourage lending institutions throughout the State of Ohio to explore the possibility of other such creative programs, and be it further RESOLVED, that the OSMA support the creative concept of the "Sallie Mae" (Student Loan Marketing Association) OPTIONS program and encourage lending institutions to

inform their borrowers of this program's existence in the hope that loan default may be avoided.

ACTION: The resolutions were passed.

Medical Student and Resident Financial Management

RESOLVED, That the OSMA-MSS appoint a committee to investigate the availability and willingness of financial investment consultants to counsel medical students and residents concerning financial problems.

ACTION: The resolution was defeated.

High Enrollment Numbers in Ohio Medical Schools

RESOLVED, That the OSMA-MSS encourage Ohio medical schools reduce the entering class enrollment in the aggregate by a minimum of 17% relative to the 1980-81 enrollment.

ACTION: Tabled for Governing Council study, to be reported back in 1984.

National Board Examinations, Parts I and II

RESOLVED, That the OSMA-MSS issue a policy statement against the utilization of any national licensure examination as a separate requirement for progression, and that this statement be forwarded to the OSMA

Homecare for Fluid Therapy

Community Alimentation Services is a professional, clinical—intravenous and nutritional support service. Our primary purpose is to serve outpatients receiving home fluid therapy — parenteral nutrition, enteral nutrition, and intravenous fluids or medication.

We are available to discuss our services with both health professionals and patients. Would a presentation on clinical nutritional support be of interest? We also offer such programs to professionals concerned with safe and appropriate outpatient or inpatient nutritional therapy.

Home Care Products

Community Alimentation Services will provide any selected products directly to the home fluid therapy and/or oncology patient.

Patient Services

All services are provided as indicated for each individual patient's safest and most effective home fluid therapy. Professional services are free of charge.

Serving the Midwest.

*For more information, call
Kevin Scheckelhoff, R.Ph.*

Director of Clinical Services

Columbus, OH (614) 464-4509

Dayton, OH (513) 263-1350

Indianapolis, IN (317) 927-0901

*Community
Alimentation
Services, Inc.*

Medical Education Committee, and be it further

RESOLVED that the OSMA-MSS issue a statement to all appropriate Ohio medical schools, encouraging them to establish school policies that NBME Parts I and II are a portion of the student's entire academic record and that the entire record be the basis for a student's progression in medical school. ACTION: The resolutions were passed.

National Board Examinations

RESOLVED, That the OSMA-MSS issue a policy statement to all Ohio medical schools informing them of its position against the utilization of any national licensure examination as a requirement for matriculation. ACTION: The resolution was withdrawn.

Listing of Free Publications

RESOLVED, That the Governing Council compile a list of free publications relevant to medical education in Ohio, and be it further RESOLVED that the Governing Council take action on generating a list of major medical journals, indicating price differences between students, residents, and practicing physicians. ACTION: The resolutions were passed.

Governing Council Compilation of Organization Information

RESOLVED, That the Governing Council compile and distribute a manual to provide individual MSS chapters with ideas for organization and growth. ACTION: The resolution was withdrawn, and will be filed for possible action in 1984.

MSS-AMA Relations Regarding Issues of Similar Concern

RESOLVED, That upon research of a given issue the AMA-MSS or OSMA-MSS consult AMSA to discover any previous research efforts or established AMSA policy on said issue, and be it further

RESOLVED, that when similar policies concerning an issue are developed independently by each organization, the AMA-MSS or OSMA-MSS work in conjunction with AMSA to obtain support for the policy from the AMA or OSMA General Assembly. ACTION: The resolution was passed, and forwarded to AMA-MSS as an Ohio delegation.

Medicine Fair

RESOLVED, That OSMA-MSS construct a planning committee detailing the feasibility study of a "medicine fair." The committee will show the purpose and effect of such a fair on the medical students and residents of Ohio to this executive committee of OSMA-MSS in six months. ACTION: The resolution was passed.

OSMA Audio-Visual Presentation

RESOLVED, That the OSMA-MSS Governing Council develop an orientation day presentation for new medical students to be used at the beginning of each medical school year. ACTION: The resolution was passed.

OSMA-MSS Orientation/Communication Binder

RESOLVED, That OSMA-MSS distribute in the fall of each year to the incoming first year class at each medical school in the State of Ohio, a durable folder binder which may include, but is not limited to include the following: (1) The organizational logo on the cover, (2) Informational and developmental materials regarding OSMA, AMA, OSMA-MSS, and AMA-MSS, (3) Any appropriate information which is compiled for distribution, for example, regarding financial aid, summer jobs, etc.; and further be it RESOLVED, that this vehicle be available to OSMA and AMA and associated organizations for delivery of communication to medical students; and further be it RESOLVED, that this project be undertaken by a committee consisting

of one student from each Ohio medical school, as appointed by the President of the OSMA-MSS, for implementation in the Fall of 1983. ACTION: The resolutions were passed.

Louis Saslaw is a Contributing Editor of the Ohio State Medical Journal.

Colleagues in the News

continued

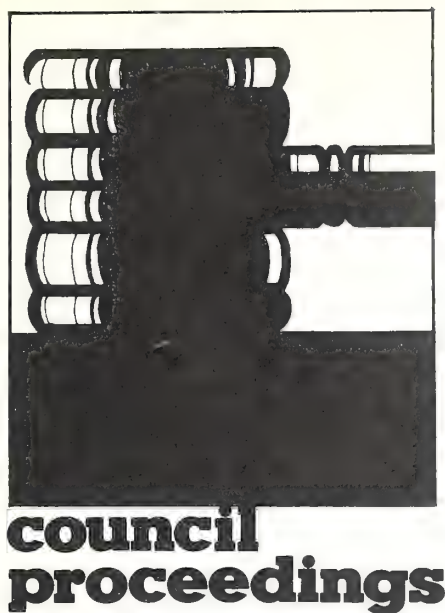
KENNETH F. RUPP, M.D., Mantua, was honored by the Creighton University School of Medicine at an alumni reunion banquet in Omaha, Nebraska. Dr. Rupp received a Silver Anniversary Citation for 25 years of service to mankind.

JACK SCHREIBER, M.D., Canfield, was honored as the Mahoning County Medical Society's fifth annual "Doctor of the Year." Dr. Schreiber is a general practitioner.

JOHN M. TEW, JR., Cincinnati, was named director of the division of neurosurgery at the University of Cincinnati Medical Center. Dr. Tew is president of the Congress of Neurological Surgeons and director of the graduate training programs in neurology at Good Samaritan and Christ Hospitals.

ROBERT J. WHITE, M.D., Cleveland neurosurgeon, has been asked by the Vatican to work with the Pontifical Academy of Science to establish a papal commission for study of the moral implications of biomedical research.

Increasing incidence
of ampicillin resistance in
shades white to



PROCEEDINGS OF THE COUNCIL

December 11, 1982

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, December 11, 1982, at the OSMA Headquarters' Office, 600 S. High Street, Columbus, Ohio.

Those present were: C. Douglass Ford, M.D., Toledo; S. Baird Pfahl, Jr., M.D., Sandusky; Stewart B. Dunsker, M.D., Cincinnati; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Edward G. Kilroy, M.D., Cleveland; J. James Anderson, M.D., Youngstown; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; James Augustine, Student Representative, Wright State University; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Oscar W. Clarke, M.D., Gallipolis, Chairman, AMA Delegation; Rose Vesper, New Richmond, President, OSMA Auxiliary; John H. Ackerman, M.D., Director, Ohio Department of Health; David W. Pennington, Worthington, President, PACO; Joseph K. Gilmore, Pickerington, President, PICO; and Robert G. Thomas, M.D.,

Elyria, OSMA Past President.

Those present from the OSMA Staff were: Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Gail E. Dodson; Robert E. Holcomb; David C. Torrens; Carol W. Mullinax; Louis N. Saslaw; Catherine M. Costello, Esq.; William E. Fry; and Carol M. Maddy.

Announcements by President Ford

Health Policy Agenda Advisory Committee — In reply to a request from the American Medical Association, Dr. Ford nominated Dr. Pfahl, Dr. Abromowitz and Dr. Claire V. Wolfe, AMA Alternate-Delegate from Columbus as candidates for service on the Health Policy Agenda Advisory Committee. The Council **ratified** these nominations.

Health Care of the Unemployed — Dr. Ford discussed the matter of health care of the unemployed and asked the Council's permission to discuss with specialty groups and county medical societies a program to deal with the matter.

The President was authorized to research and implement an organization to assist the "temporary medically indigent" and to establish measures for their health care.

Ohio State Medical Board — The Council **approved** a letter from President Ford to the president of the Ohio State Medical Board concerning legislation designed to establish a workable mechanism to identify those graduates of foreign schools of medicine whose schools are not accredited by LCME or AOA, but whose medical and professional skills are such that these graduates are qualified to sit for a licensure examination.

Administration

Mr. Page presented, and the Council approved, a report on the OSMA Travel Program, including the schedule for 1983.

The Executive Director introduced

Aristotle Hutras, new member of the legislative staff.

Mr. Page announced that Mr. Mulgrew has been elected to the Board of Directors of the Ohio Society of Association Executives.

Ohio Medical Political Action

Committee — Dr. Ford announced that the Ohio Medical Political Action Committee has elected the following officers:

A. Burton Payne, M.D., Ironton, Chairman

Jerome Kimmelman, M.D., Toledo, Vice Chairman

John E. Albers, M.D., Cincinnati, Secretary

Three new board members elected were:

William T. Paul, M.D., Columbus

John H. Boyles, Jr., M.D., Dayton

Theodore J. Castele, M.D., Cleveland

The Council voted to extend its thanks and appreciation to retiring directors: Dr. H. William Porterfield, Columbus; Dr. W. Jack Lewis, Dayton; and Wesley Pignolet, Willoughby.

Financial and Membership Department

Mrs. Wisse pointed out that as of December 1, membership is ahead of December 31, of last year.

Treasurer's Report — Dr. Barr presented the report of the Treasurer. The report was accepted.

Department Report — Mrs. Wisse presented the written report of the Financial and Membership Department and it was filed.

Committee on Membership — Mrs. Wisse presented the minutes of the November 10, 1982 meeting of the Committee on Membership. The report was filed.

Committee on Auditing and Appropriations — Dr. Payne presented the minutes of the December 10, 1982 meeting of the Committee on Auditing and Appropriations.

By official action, the budget for

1983 was approved.

The Council approved the recommendation of the committee with regard to increases in billings for specialty society services.

The committee recommended, and the Council agreed, that the OSMA match county medical society and medical school reimbursement of expenses for students attending the AMA Student Section Meeting of the AMA Annual and/or Interim Session.

A maximum of \$750 per meeting, per student delegate, was established.

If a student delegate is underfunded by the county society or medical school funding, such case will be individually reviewed.

In accordance with the action of the Council, the above program will be reevaluated after one year.

The Council appropriated \$17,500 for the proposed study of professional liability insurance companies.

The report of the committee, as a whole, was approved.

Department of Education & Meeting Management

Mrs. Dodson presented the written report of the Department and it was filed.

Committee on Emergency & Disaster Medical Care

Mr. Torrens presented the minutes of the November 3, 1982 meeting of the Committee on Emergency & Disaster Medical Care. The minutes were filed.

Department of Government Relations

Mr. Gillen presented the written report of the Department of Government Relations and it was filed.

Committee on Cost Effectiveness —

Mr. Fry presented the minutes of the November 19, 1982 meeting of the Committee on Cost Effectiveness and they were approved.

The Tax Equity and Fiscal

Responsibility Act of 1982 (TEFRA) — A summary of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), issued by the AMA Board of

Trustees, was distributed to the Council.

Ohio Voluntary Effort — Mr. Gillen announced the termination of the Ohio Voluntary Effort (OVE) as an organization.

He stated that the OSMA, the Ohio Hospital Association and the Ohio Association of Osteopathic Physicians & Surgeons will continue to meet on a staff level.

Department of Organizational Services

Mr. Campbell presented the written report of the Department and it was filed.

American Medical Association — Dr. Clarke presented the report of Ohio's AMA Delegation.

He reviewed the December meeting of the AMA and announced that the Ohio resolution on Emergency Medical Service Personnel was referred to the AMA Board of Trustees.

Physicians Insurance Company of Ohio

— Mr. Gilmore addressed the Council with regard to PICO developments, specifically reviewing assets (100 million dollars); surplus; reserves; and premium income of PICO and its related corporations.

Mr. Gilmore and Dr. Thomas discussed transportation requirements in the administration of PICO.

Department of Health Education

Mr. Clinger presented the written report of the Department and it was filed.

He announced that the Committee on Cancer will, at the February 5 meeting of the Council, report to the Council on a data gathering program proposed by the Cancer Control Consortium of Ohio, Inc.

Department of State & Federal Legislation

Mr. Mulgrew discussed H.B. 173, the OSMA Hospital Licensure Bill which was signed December 2, 1982 and becomes effective March 3, 1983.

An overview of the 114th Ohio General Assembly was presented in

writing and it was filed.

Mr. Mulgrew reviewed the recent vote on the Federal Trade Commission legislation which would provide for a moratorium on the agency's supervision of the professions.

Ms. Costello reported on state legislative activities and the completion of a number of legislative tasks including three new laws:

H.B. 605, to provide child safety restraints in automobiles, **S.B. 4**, eliminating terminal district licenses for physicians, and **S.B. 432**, the tough drunk driving bill.

Medicaid hearings and testimony by Dr. Pfahl, President-Elect, were discussed.

Ms. Costello presented rules for Limited Maternity Units, as proposed by the Ohio Public Health Council.

The rules involve "free-standing birth centers" as an alternative to the traditional hospital unit for small hospitals in rural areas.

The matter was referred to the OSMA Committee on Maternal and Neonatal Health for evaluation and report back in time for consideration by the Council in advance of the hearings by the Ohio Public Health Council.

The Council voted to inform the Ohio Public Health Council of the Association's intent to provide testimony on the matter.

The minutes of the Committee on State Legislation meeting on November 23 were accepted for information.

Department of Communications

The written report of the Department of Communications was submitted by Ms. Doll, and was filed.

Ms. Doll reviewed her visit to the Lorain County Senior Action coalition. The Council expressed the opinion that the Lorain County Medical Society has responded to the concerns of the group and that the organization be advised that OSMA will not participate in their proposed hearings.

Art and Culture Committee — Ms. Mullinax presented the minutes of the September 25, 1982 meeting of the Committee on Art and Culture.

Focus Group Interviews — Focus group interviews in Wooster were

reviewed by Ms. Mullinax.

Department of Marketing and Field Service

Mr. Holcomb presented the Department's written report, which was accepted and filed.

Legal Counsel Report

PICO Building Lease — Mr. Pohlman presented a resolution on the lease of PICO Building II to PICO.

The resolution was approved, on a motion by Dr. Abromowitz, seconded by Dr. Pfahl, and is attached to the December 11, 1982 minutes of the Council.

OSMA Auxiliary

Mrs. Vesper submitted her written report and a copy of the **Auxiliary News**. The report was filed.

Physicians Administrative Corporation of Ohio

Mr. Dave Pennington reported on developments and the expansion of PACO marketing activities with the cooperation of key county medical societies.

He announced the increased popularity and utilization of the tape-to-tape billing program.

He said that projections for next year are indicating a million dollars in sales and a healthy growth of the company.

He announced seven practice management seminars to be sponsored by PACO in early 1983.

The President thanked Mr. Pennington and his staff for their successful program of work.

Ohio Department of Health

Dr. John Ackerman, Ohio Director of Health, addressed the Council.

He announced the approval by his agency for the establishment of a Cancer Hospital at the Ohio State University College of Medicine.

The Council voted to commend Dr. Ackerman, who is leaving the department to accept another position, for his long years of service to the patients of Ohio and expressed the Council's appreciation for his participation in its discussions.

There being no further business, the meeting was adjourned. The next meeting of the Council is scheduled for February 5, 1983.

ATTEST: Hart F. Page, CAE
Executive Director

/cm

December, 14, 1982

10 th District

Councilor: *D. James Hickson, M.D.*, Box 208, Mt. Gilead 43338.

DELAWARE: Thomas P. Hubbell, M.D., President, 494 W. Central Ave., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 141 S. Main St., Prospect 43342. Third Tuesday. Mar., May, Sept., Dec.

FAYETTE: Robert Heiny, M.D., President, Box 457, Washington C.H. 43160; Marvin H. Roszmann, M.D., Secretary-Treasurer, P.O. Box 547, Washington C.H. 43160. Second Tuesday.

***FRANKLIN:** James E. Barnes, M.D., President, 931 Chatham Lane, Columbus 43221; Howard W. Lowery, M.D., Secretary-Treasurer, 3545 Olentangy River Road, Columbus 43214; James S. Imboden, Executive Director, 600 S. High St., Columbus 43215, 614/224-6116. Feb., Aug., Sept., Oct.

***KNOX:** James H. Risko, M.D., President, 307 Verndale Dr., Mt. Vernon 43050; Edward Yu, M.D., Secretary-Treasurer, 20 S. Ridge Dr., Mt. Vernon 43050. First Wednesday.

MADISON: J. Richard Hurt, M.D., President, 35 S. Twin St., West Jefferson 43162; C. C. Lin, M.D., Secretary-Treasurer, P.O. Box 148, West Jefferson 43162. Second Wednesday, quarterly.

MORROW: Francis Kubbs, M.D., President, 140 N. Main St., Mt. Gilead 43338; Parviz Meftah, M.D., Secretary-Treasurer, 152 W. High St., Mt. Gilead 43338. First Tuesday.

PICKAWAY: Gary Gillen, M.D., President, 111 Island Road, Circleville 43113; Lynn Chrismer, M.D., Secretary-Treasurer, 610 Northridge Road, P.O. Box 516, Circleville 43113. Second Tuesday.

ROSS: David McKell, M.D., President, 60 Central Center, Chillicothe 45601; Donald L. Berling, M.D., Secretary-Treasurer, P.O. Box 787, Chillicothe 45601. First Thursday.

UNION: Paul R. Zaugg, M.D., President, 225 Stocksedale Dr., Marysville 43040; May B. Zaugg, M.D., Secretary-Treasurer, 509 Hickory Dr., Marysville 43040. First Tuesday, Feb., Apr., Oct., Dec.

11 th District

Councilor: *D. Ross Irons, M.D.*, 813 Northwest St., Bellevue 44811.

ASHLAND: Syed I. Ali, M.D., President, Samaritan Hospital, 1025 Center St., Ashland 44805; Katherine Hess, M.D., Secretary-Treasurer, 934 Center St., Ashland 44805. First Tuesday.

ERIE: Albert O'Halloran, M.D., President, Providence Hospital, Sandusky 44870; Douglas C. Rist, M.D., Secretary, 2528 Columbus Ave., Sandusky 44870; Mrs. Barbara Wolfert, Executive Secretary, 2710 Scheid Road, Huron 44839, 419/433-3097. Second Tuesday except July and August.

HOLMES: Daniel J. Miller, M.D., President, Box 143, Walnut Creek 44687; Kim Boyd, M.D., Secretary-Treasurer, Box 143, Walnut Creek 44687. Second Monday.

HURON: Theodore Ball, M.D., President, 423 W. Main St., Bellevue 44811; Ronald Winland, M.D., Secretary-Treasurer, 266 Benedict Ave., Norwalk 44857. Second Wednesday, Feb., Apr., June, Oct., Dec.

LORAIN: M. A. Amiri, M.D., President, 201 W. 21st St., Lorain 44052; Kenneth Bescak, M.D., Secretary-Treasurer, 3600 Kolbe Road, #105, Lorain

44053; Mrs. Alice Waite, Executive Secretary, 110 Sheffield Center, Lorain 44055, 216/324-3093. Second Tuesday, Sept. - April.

MEDINA: H. Linn Mast, M.D., President, 970 E. Washington St., Medina 44256; Ralph G. Fennell, M.D., Secretary-Treasurer, 3430 Huffman Road, Medina 44256; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256, 216/725-5331. Third Thursday.

RICHLAND: James D. Curry, M.D., President, 335 Glessner Ave., Mansfield 44903; P. Padival, M.D., Secretary-Treasurer, 275 Cline Avenue, Mansfield 44907; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903, 419/524-2671. Third Thursday except June, July and August.

WAYNE: Gerald W. Steiner, M.D., President, 1740 Cleveland Road, Wooster 44691; Daniel Stump, M.D., Secretary-Treasurer, 1761 Beall Ave., Wooster 44691. Second Wednesday every second month.

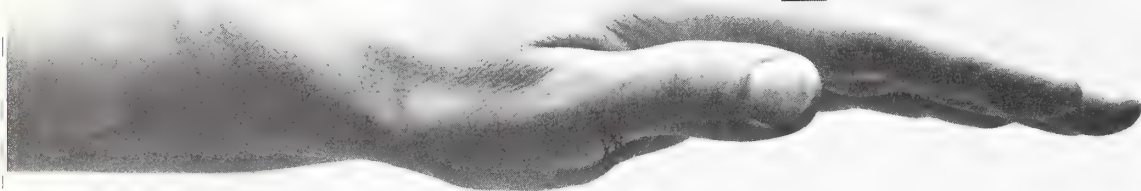
12 th District

Councilor: *Joseph L. Kloss, M.D.*, 737 Ridgecrest Road, Akron 44303.

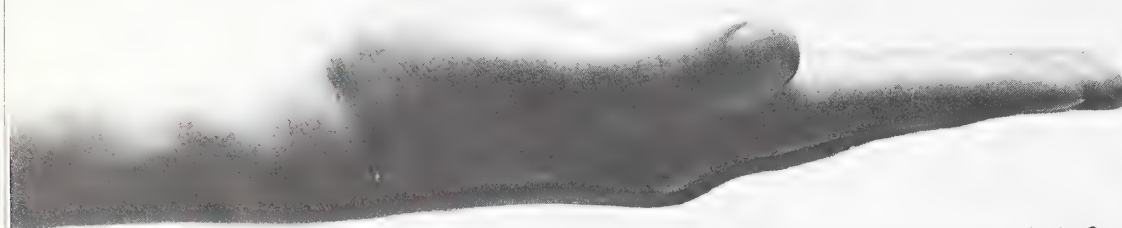
PORTAGE: Robert Egdell, M.D., President, c/o Portage County Medical Society, 152 N. Water St., Kent 44240; Atila N. Can, M.D., Secretary-Treasurer, c/o Portage County Medical Society, 152 N. Water St., Kent 44240. Second Tuesday.

SUMMIT: Paul D. Gatewood, M.D., President, 1815 W. Market St., Akron 44313; C. William Keck, M.D., Secretary, 177 S. Broadway St., Akron 44308; Mrs. Shirley Bee, Managing Director, 430 Grant St., Akron 44311, 216/434-1921. First Tuesday, Jan., Mar., May, Sept., Dec.

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NEW MEMBERS

ALLEN

Eugene B. Rosenberg, Lima

BELMONT

Joseph C. Samaras, Bellaire

COLUMBIANA

Hira Rohela, East Liverpool

DARKE

Mary Beth Cass, Greenville
Joseph H. Engle, Greenville

FULTON

Keith Lehman, Archbold

GALLIA (Gallipolis unless noted)

Moien R. Butt
Susanne Mize
Mark A. Walker

GUERNSEY (Cambridge unless noted)

Suranjan Ray
Shashi M. Vora

HAMILTON (Cincinnati unless noted)

William E. Halperin
Peter Y. C. Ho
Dennis Hoeffler
S. Bernadette Kim
Deborah Silverman
Richard J. Stevenson
Robert Thaler

HANCOCK (Findlay unless noted)

Robert L. Heacock
Timothy Kelly
Ralph E. Reeds, Jr.
Edwin S. Watts

JEFFERSON

Samuel Glass, Steubenville

KNOX

Jawahar Palaniappan, Mt. Vernon

LAKE

Prathap G. Chrandran, Painesville
Boushra Ward, Mentor
Robert Kakish, Mentor

LAWRENCE

V. Satyanarayan Kadim,, Ironton

LICKING

Jackie L. Underwood, Newark

LORAIN

Martin Bukowski, Lorain
John Cardella, Vermilion
Roger Allen Hale, Lorain
Vagesh Hampole, Elyria
Daniel J. Holden, Lorain
Rodney Lynk, Elyria
Pareshkumar A. Patel, Elyria
John Pecorak, Lorain
Kenneth Weiner, Lakewood

MAHONING

Roop K. Kolipara, Youngstown
Arturo P. Mirasol, Poland

MARION (Marion unless noted)

Teferi Asfaw
Bernard Nowacki
Philip Oppenheimer
Robert Warner

MERCER

Paul H. Boleski, Celina

MIAMI

Thomas J. Nickras, Troy

MUSKINGUM

Daniel B. Scheerer, Zanesville

PORTAGE

Roger A. Tsai, Ravenna

ROSS (Chillicothe unless noted)

John Du Puis
Tae Won Kim
William H. Schutten

SANDUSKY (Fremont unless noted)

J. Michael Hazlett
Kelly Randall

SHELBY

Miguel Topalov, Sidney

STARK (Canton unless noted)

Neelam Arora, Massillon
Rakesh K. Arora
Geoffrey C. Lamb
Martha W. Magoon
Jeffrey B. Miller, Massillon
Georgy W. Rutecki

SUMMIT (Akron unless noted)

Carlos A. Budding, Barberton
Bryce S. Clubb
Robert J. Donahue
John R. Jeanmaire
Franklin W. Kokomoor
David W. Rindfusz

TUSCARAWAS

Mushtaf Ahmad Khan, Dover

WAYNE

Dogan Bozkir, Orrville
W. Blair Geho, Wooster
John K. Miller, Wooster

Continuing Education Programs

continued

9:00 AM

Urological Aspects of Endourology
— Paul H. Lange, M.D., Professor of Urology, University of Minnesota Medical Center and Chief of Urology, Veterans Administration Medical Center, Minneapolis, Minnesota

10:00 AM

Practical Aspects of Establishing Endourology in a Community Hospital
— David E. Klein, M.D., Assistant Clinical Professor of Urology, Case Western Reserve University Medical Center, Cleveland

10:30 AM

Radiological Aspects of Endourology
— Joseph P. LiPuma, M.D., Professor of Radiology, Case Western Reserve University Medical Center, Cleveland

11:00 AM

Panel Discussion: Question and Answer Period

12:00 Noon

Luncheon, Clark Room

1:30 PM

Business Meeting

****NOTE: Programs received at the time of publication.**

Obituaries

THOMAS J. BALL, M.D.,
Cincinnati; St. Louis University
College of Medicine, 1959; age 50; died
January 28, 1983; member OSMa and
AMA.

FRANCES K. HERWIG, M.D.,
Plantation, Florida; Medical College of
Pennsylvania, Philadelphia, 1924; age
96; died January 1983; member OSMa
and AMA.

SAMIR E. KADI, M.D., Akron;
Medical School, American University,
Beirut, Lebanon, 1960; age 49; died
February 7, 1983; member OSMa and
AMA.

NESTER NARCELLES, M.D.,
Zanesville; Institute of Medicine, Far
Eastern University, Manila,
Philippines, 1960; age 46; died January
29, 1983; member OSMa and AMA.

CARMALA SHAMESS, M.D.,
Mansfield; University of Toronto
Faculty of Medicine, Toronto, Ontario,
1944; age 63; died January 27, 1983;
member OSMa and AMA.

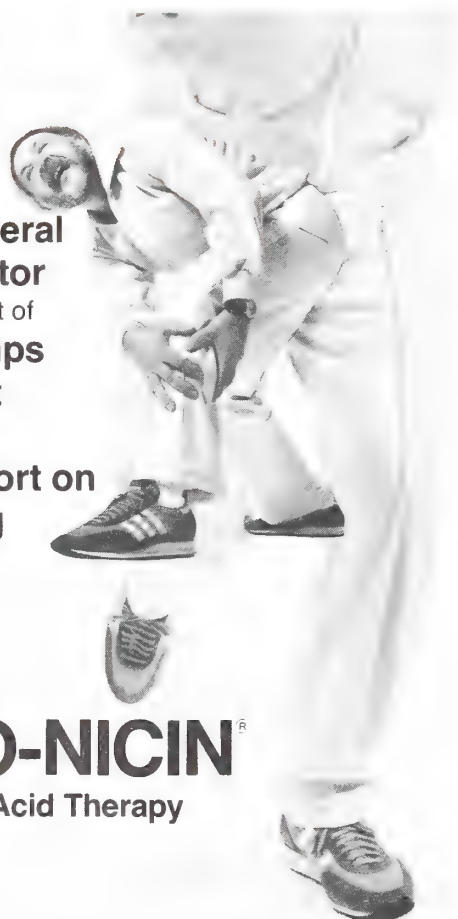
PEARL O. STAKER, M.D., Key
Colony, Florida; Ohio State University
College of Medicine, 1943; age 67; died
November 29, 1982; member OSMa
and AMA.

JOHN C. STARLING, M.D.,
Cleveland; Meharry Medical College
School of Medicine, 1942; age 67; died
January 25, 1983; member OSMa and
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RICHARD L. WAGNER, M.D.,
Wheelersburg; Jefferson Medical
College, Thomas Jefferson University,
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Correction

In the "Guide to Ohio Markets" article, printed in the February issue of the Ohio State Medical Journal, it was mentioned that Humana, Inc. soon will be operating its new hospital in the Dayton area. In fact, Humana, Inc. will be opening a new MedFirst facility there, and not a hospital as written.

Abuse in UCR: A Financial Bonanza for Physicians

continued

appear to reason that the public be damned as they reach their goal of great wealth in the shortest period of time. Today, highly respected older surgeons in this country are beginning to protest this greedy direction of the practice of medicine in the United States, and they are having their protest in various medical journals for their colleagues to read and act upon. Observations, written by Dr. Benson B. Roe, chairman of the American Board of Thoracic Surgery¹ and Dr. Robert M. Zollinger, former president of the American College of Surgeons,² put the problem at hand into proper perspective. The factual observations of Professors Roe and Zollinger should be required reading for all those who seek to remedy the frequent, serious abuse of doctor fee schedules for financial gain.

Considering human nature to be what it is, where greed for wealth and fame not infrequently raises its ugly

Considering human nature to be what it is, including in the healing arts, it appears unlikely that the medical profession will remedy this problem.

head in all professions, including that of the healing arts, it appears most unlikely that the medical profession as a whole will ever remedy the disturbing problem. Until I learned otherwise, as a long-time American board-certified specialist in mostly gynecologic surgery, I had been a most avid proponent of the concept of "usual, customary and reasonable fees" in the private practice of

medicine. However, the current widespread abuse of UCR by increasing visible segments of the medical profession has caused me to take a strong opposing stand to my former viewpoint.

It is proposed that the federal government in Washington speedily convene a Select Ad Hoc Committee, including peer review, to consider, among other things, the preparation of "usual, customary and reasonable fees" for doctors to use in the daily practice of medicine. And great care should be taken to make certain that this fee schedule keeps pace with new costs and new developments as they occur in the future. The American public deserves no less!

Leonard B. Greentree, M.D., is a member of the OSMA and practices OB-GYN in Columbus.

References

1. Roe BB: The UCR Boondoggle: A death knell for private practice, *N Eng J Med*, 305:41-45, 1981.
2. Zollinger RM: Holding fees in line, *Bulletin American College of Surgeons*, 67:2-3, 1982.

Physicians alerted to TCDD dangers

Physicians across the country are being alerted by the American Medical Association to watch for signs of adverse effects in certain patients exposed to a chemical contaminant of Agent Orange known as TCDD.

The alert is in a report published in a recent issue of the *Journal of the American Medical Association* that is based on a review by the AMA Council on Scientific Affairs of the medical evidence of toxicity and long-term health effects on Agent Orange.

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patients are taken off of all addicting drugs for pain.

For more information on Harmarville...its pain program and admission procedures, call John F. Delaney, M.D. or Mary Anne Murphy, Ph.D. at 781-5700.



Harmarville Rehabilitation Center, P.O. Box 11460, Guys Run Road, Pittsburgh, PA 15238

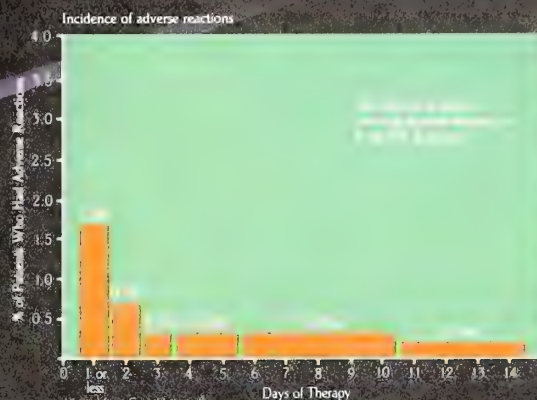
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Dalmane also rarely causes morning hangover.^{1,6,7} In one study of 2542 patients, the incidence of adverse reactions reported with Dalmane was only 3.1%. Most of the side effects occurred after the first night of therapy; the incidence declined as therapy continued.⁷ Thus, accumulation of the N₁-desalkyl-flurazepam metabolite of Dalmane is not associated with an increased incidence of morning hangover. But patients should be cautioned about driving or drinking alcohol during therapy. Because the risk of dizziness, oversedation and ataxia increases with higher dosages in the elderly and debilitated, the dosage should be limited to 15 mg in these patients. Dalmane is contraindicated in pregnancy.

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. deSilva JAF, Bekersky I, Puglisi CV. *J Pharm Sci* 63:1837-1841, Dec 1974. 3. Kaplan SA et al. *J Pharm Sci* 62:1932-1935, Dec 1973. 4. Kales A et al. *Clin Pharmacol Ther* 18:356-363, Sep 1975. 5. Kales A et al. *J Clin Pharmacol* 17:207-213, Apr 1977, and Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Somerman AM. *Curr Ther Res* 13:18-22, Jan 1971. 7. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21:355-361, Mar 1977. 8. Kales A et al. *JAMA* 241:1692-1695, Apr 20, 1979. 9. Monti JM. *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981.



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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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The Bequest

By C. Douglass Ford, M.D.

It is traditional to thank everyone who has been of assistance when you have finished a term in office. I do so gratefully, not traditionally. Without the members of Council, members of committees, County Medical Society leaders, and other involved members of our Association, the thing would not have been as high on the wave. I am grateful, too, for the warm and constructive support of staff; not only our remarkable county executives, but the superb OSMA staff, as well. Without them, the thing would not have gotten out of the trough.

Dr. Pfahl has "inherited" an exciting, active Association of 16,000 physicians which over the years, has changed its relationship with those members. It began in the 1970s when, for the first time, the Association formed a for-profit subsidiary which entered the market for the insurance business of its members. The Physicians Insurance Company (PICO) has grown rapidly, and the OSMA, its members, and PICO's stockholders have profited. The medical liability

Dr. Pfahl is, as well, the "inheritor" of PACO, another OSMA for-profit subsidiary. This fledgling company has been organized to sell administrative services to physicians. PACO began by submitting batched Medicaid claims to the Welfare Department. The advantage was reduction of payment turn-around time to a few weeks as opposed to the several months that passed before payment would be received when paper claim forms were submitted.

Prices for this service dropped to about 25% of the existing rates after PACO entered the market. That price reduction, too, has benefited Ohio's physicians, be they users of PACO's service or not.

Now, PACO has embarked upon marketing a medical office computer system which impressed me sufficiently enough that I purchased one. I think it is the best "package" available currently. It has an exceptionally large data storage capacity coupled with user-helpful and diversified programming.



C. Douglass Ford, M.D.

Association will become a reliable resource for many of the needs that the practice of medicine produces. OSMA membership will become more rewarding and satisfying, in my opinion.

I expect Dr. Pfahl to be an outstanding President. He is a man with the necessary intellect, compassion, and energy needed to lead the OSMA upon a course that is both meaningful and responsive to you, the member. No organization, regardless of its merit, is capable of surviving indifferent leaders. The OSMA is in no such jeopardy with Dr. Pfahl.

Dr. Pfahl has "inherited" an exciting, active Association of 16,000 physicians which, over the years, has changed its relationship with those members.

market in Ohio has reopened, and the competition which has developed has helped keep the premiums from escalating at their previous rate — all of which helps Ohio's physicians control their overhead, regardless of their insurance carrier.

PACO will assist members with marketing problems, practice management problems, and with many other facets of an efficient and competitive practice. The list will grow.

Through the OSMA subsidiaries, the

C. Douglass Ford, M.D., Toledo, is President of the Ohio State Medical Association

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahiolu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When Impotence is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{Oral} / 25^{Oral} mg.
Methyltestosterone U.S.P. Tablets
A well absorbed oral androgen

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

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Letters ...to the editor

To the Editor:

In the February 1983 issue of the Ohio State Medical Journal, I note a probable error in the article titled "The Guide to Ohio's Markets." On page 122, it states "Cleveland does support a staff model HMO. . ." If reference is to the Kaiser-Permanente Medical Care Program of Ohio, it is incorrect. The Kaiser-Permanente Medical Care Program is a group model HMO rather than a staff model. The difference between the two models is real and substantial, with the group model physicians organized as an independent medical group while staff model physicians are employed by the HMO.

Yours truly,

/s/Sam Packer, M.D.

Kaiser-Permanente Medical Center
Cleveland, Ohio 44120

FROM THE EDITOR'S DESK

The Aging of America Are We Ready?

Not so long ago, Americans grew old without anyone really thinking much about it. Social security provided them with a pension to live on, and Medicare picked up the bill when they were ill. Most of them were cared for by concerned families and friends, and when their health declined to such a stage that they needed round-the-clock nursing, then a variety of nursing homes and institutions were available to provide the necessary care.

But times have changed, and suddenly the rapidly increasing aging population in America has put an entirely different light on the process of growing old. Leaders in business, sociology, economics and medicine are beginning to realize that, as more and more people grow old and live longer, a vast strain is going to be placed on our society. Are we ready to handle the social, economic and medical drain of our resources which an aging population means?

This issue of the *Journal* attempts to examine some of the problems created by the Aging of America. Robert Binstock, Ph.D., the Director of the Policy Center on Aging at Brandeis University, provides a broad overview of the subject in "The Rocking Chair Dilemma," and Cary Kart, M.D., of the University of Toledo, localizes

these views in "Old Age in Ohio."

The *Journal* then turns to some of the specific problems raised by these two authors. "Home, Crowded Home" examines the issue of overcrowded nursing homes in our state.

"Geriatrics, Our Profession's New Responsibility," and "Who Will Take Care of Me?" look at the current practice of geriatric medicine — and where this specialty is headed in the future. "Hospitals: Their Changing Role," discusses how these health care providers are evolving to meet the needs of elderly patients, and a Columbus neurologist writes about one of the biggest medical problems physicians will face in the future. . . "Dealing with Dementia."

And just so you don't forget your own future in the context of this problem, we've included an article "Retirement Is Not a Dirty Word."

We're especially proud of a new feature we're adding this issue, "PR Practice," which will provide tips on how to communicate more efficiently with your staff, your patients, and your public. Watch for it.

If you have any comments about this issue, or any of the articles, please write and let us know.

—Karen S. Edwards
Executive Editor

**HYPERTENSION
PROTECTION
AND MORE.**



START WITH INDERAL[®] (PROPRANOLOL HCl). THE REASONS HAVE NEVER BEEN BETTER.

INDERAL, a logical first step

Unlike thiazide diuretics, which can provoke serious reductions of serum potassium, INDERAL has been found to maintain or modestly increase serum potassium levels.^{1,2} Therefore, the consequences of hypokalemia — including the threat of ventricular arrhythmias² — may be significantly reduced.

INDERAL acts to reduce catecholamine-induced "spiking" of blood pressure which often coincides with the physical and emotional stress in a hypertensive's life.³ INDERAL reduces elevated heart rate, force of ventricular contraction, and cardiac work load — providing smooth control of hypertension to decrease the risk of related cardiovascular complications. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.)

INDERAL works in a way that non-beta blockers can't—to provide long-term cardiovascular benefits.

INDERAL provides treatment for coexisting angina pectoris or cardiac arrhythmias in addition to reducing blood pressure — for comprehensive protection. What's more, INDERAL is well tolerated, acting with few of the distressing side effects of antihypertensive agents such as methyldopa or reserpine. Impotence, depression, sedation, orthostatic hypotension, and nasal stuffiness are rare. (Please see following page for Brief Summary of Prescribing Information, including side effects of INDERAL.)

Indeed, INDERAL has changed the face of antihypertensive therapy, worldwide. And it continues to do so — with an unparalleled record of clinical efficacy and experience.

INDERAL. It's the kind of protection hypertensive patients need — right from the start.

References: 1. Traub, Y.M., et al.: Clin. Pharmacol. Ther. 28:765 (Dec.) 1980.
2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. 647 (Suppl.):67, 1981.
3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

INDERAL[®] (PROPRANOLOL HCl)

Comprehensive Cardiovascular Protection

Please see following page for brief summary of prescribing information.

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(PROPRANOLOL HCl)

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
Inderal[®] (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS,

EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. **Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (propranolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

— Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

— Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

— Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

— Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-99).

— Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTION

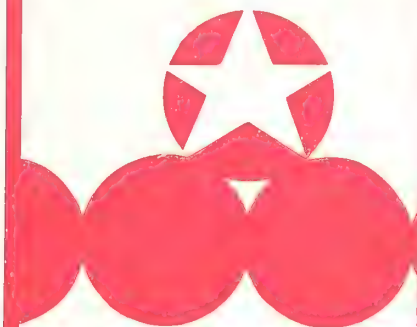
— Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).



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COLLEAGUES IN THE NEWS



HOMER ANDERSON, M.D., Columbus, was reelected president of the board of trustees of the Medical Bureau. **JAMES MATSON, M.D.**, Columbus, was elected secretary-treasurer.

A. J. ANTALIS, M.D., was elected vice chief of staff of Bellaire City Hospital, and **NORMAN FRANKLIN, M.D.**, was elected secretary-treasurer.

WILLIAM H. BUNN, M.D., Youngstown, was named vice president of medical affairs at Youngstown Hospital Association. He is chief of the division of medicine at YHA, and professor of medicine at Northeastern Ohio Universities College of Medicine where he is also chairman of the department of medicine, Year V Curriculum Committee and the primary care committee. Dr. Bunn has been active for more than 25 years in the American Heart Association, which he serves as a regional vice president and chairman of its North Central Heart Committee.

DONALD F. CAMERON, M.D., Bryan, was honored with a plaque in recognition and appreciation of his service to the Board of Directors of Bryan Community Hospital.

The following were elected officers of the Ohio State Medical Board: **OSCAR W. CLARKE, M.D.**, internist, Gallipolis, president; **LEONARD L. LOVSHIN, M.D.**, internist, Cleveland, vice-president; and **ANTHONY RUPPERSBERG, JR., M.D.**, obstetrician/gynecologist, Columbus, secretary-treasurer.

WILLIAM J. CLEARY, JR., M.D., Youngstown, was elected president of the Rotary Club of Youngstown. Dr. Cleary is an internist on the staff of St. Elizabeth Hospital Medical Center. Appointed president-elect was **Y.T. CHIU, JR., M.D.**

The Community Action Commission of the Cincinnati area presented a plaque commemorating the life and work of **AMBROSE H. CLEMENT, M.D.**, during the official dedication services for the Ambrose H. Clement Clinic. Dr. Clement served the community, as a surgeon, from 1958 until his death in July 1982.

DALE H. COWAN, M.D., Shaker Heights, was appointed to head the Division of Medical Oncology and Hematology at Marymount Hospital. Dr. Cowan also acts as chairman of the Cancer Committee for the medical staff.

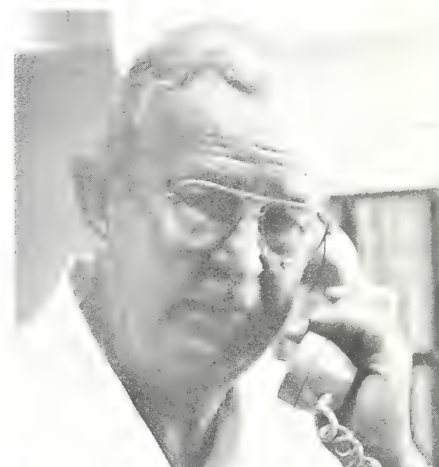
CHAD DUNKLE, M.D., was appointed chief of staff at Mercy Hospital's north unit in Hamilton, and **RICHARD KEYS, M.D.**, was appointed chief of staff of the south unit in Fairfield.

JOSEPH C. EICHEL, M.D., Zanesville, a family practitioner, is the medical consultant to the Ravenwood alcoholism treatment program.

ADOLFO GAMES, M.D., Warren, was reelected president of the medical staff of Trumbull Memorial Hospital. Other officers elected were: **CHARLES ANDERSON, M.D.**, vice president, and **EDMONDO SALERO, M.D.**, secretary-treasurer.



Oscar Clarke, M.D., Gallipolis, president, Ohio State Medical Board.



Anthony Ruppertsberg, Jr., M.D., Columbus, Medical Board's secretary-treasurer.

GEORGE HORST, M.D., West Liberty, was elected president of the Adriel School, Inc. board of trustees. Adriel School is a multiservice treatment center which serves children with learning and behavior problems. Dr. Horst is an assistant chief with the Ohio Department of Health's Bureau of Preventive Medicine.

The following were elected officers of the medical staff of Deaconess Hospital in Cincinnati: **ARTHUR L. HUGHES, M.D.**, president; **MALCOLM MEYN, M.D.**, president-elect; and **KENNETH HEHMAN, M.D.**, secretary-treasurer.

New officers of the medical staff of St. Alexis Hospital are: **RALPH KOVACH, M.D.**, orthopedic surgeon, president; **FREDERICK CROSS,**

continued on page 331

AYERST LABORATORIES ANNOUNCES

Acetaminophen with codeine: the preferred tablet form in tamper-resistant bottles.



Today's most wanted & analgesic formula...
in today's most wanted form.

TABLETS

ANACIN-3

ACETAMINOPHEN

with Codeine



15 mg, 30 mg, 60 mg

Each tablet contains acetaminophen and codeine phosphate* as follows:

acetaminophen, 325 mg and codeine phosphate*, 15 mg (1/4 gr)

acetaminophen, 300 mg and codeine phosphate*, 30 mg (1/2 gr)

acetaminophen, 300 mg and codeine phosphate*, 60 mg (1 gr)

*WARNING: May be habit forming.

Please see adjacent page for brief summary of prescribing information



Brief Summary (For full prescribing information see package insert.)

Description: Each Tablet Contains

Acetaminophen 325 mg, and Codeine Phosphate*, 15 mg
Acetaminophen 300 mg, and Codeine Phosphate*, 30 mg
Acetaminophen 300 mg, and Codeine Phosphate*, 60 mg

*WARNING: May be habit forming

Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: Drug Dependence: Codeine can produce drug dependence of the morphine type, and may be abused. Dependence and tolerance may develop upon repeated administration. Prescribe and administer with the same degree of caution appropriate to the use of other oral narcotic medications. Subject to the Federal Controlled Substances Act (Schedule III).

Precautions: Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Information for Patients: Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking this drug should be cautioned accordingly.

Drug-Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety, or other CNS depressants (including alcohol) concomitantly with acetaminophen and codeine may exhibit additive CNS depression due to the codeine component. When such therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine.

The concurrent use of anticholinergics with codeine may produce paralytic ileus.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, acetaminophen and codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Nursing Mothers: It is not known whether the components of this drug are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when acetaminophen and codeine are administered to a nursing woman.

Adverse Reactions: Most frequently: Lightheadedness, dizziness, sedation, shortness of breath, nausea and vomiting. More prominent in ambulatory than in non-ambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Others: Euphoria, dysphoria, constipation and pruritus.

Dosage and Administration: Dosage should be adjusted according to severity of pain and response of the patient. However, it should be kept in mind that tolerance to codeine can develop with continued use and that the incidence of untoward effects is dose related. This product is inappropriate even in high doses for severe or intractable pain. Adult doses of codeine higher than 60 mg fail to give commensurate relief of pain but merely prolong analgesia and are associated with an appreciably increased incidence of undesirable side effects. Equivalently high doses in children would have similar effects.

Adults: **Codeine**—15-30 mg (for mild to moderate pain)
60 mg (for moderate to moderately severe pain)

Acetaminophen—300-600 mg

Children: **Codeine**—500 mcg/kg

Doses can be repeated up to every 4 hours.

Full directions for use should be consulted prior to administering or prescribing.

Manufactured by KV Pharmaceutical Co., St. Louis, Missouri 63144 8256

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R
Anacin-3[®] Codeine 30 mg
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Disp: #28

Colleagues in the News

continued

M.D., thoracic and cardiovascular surgeon, president-elect; and **ANA HIRSCH, M.D.**, dermatologist, secretary-treasurer.

The following were elected to the board of trustees of Physicians Peer Review Association, Inc.: (Mahoning County) **JAMES A. LAMBERT, M.D.**; **EDWARD A. SHORTEN, M.D.**; **MARSHALL E. LOWRY, D.O.**; **HAROLD J. REESE, M.D.**; and **FREDERICK L. SCHELLHASE, M.D.** (Stark County) **ROBERT R. HIRST, M.D.**

GEORGE LEICHT, M.D., North Olmsted, was elected president of the Cleveland Health Education Museum board of trustees. Dr. Leicht is an obstetrician and gynecologist.

WILLIAM D. LOESER, M.D., Youngstown, was elected to the board of trustees of the Youngstown Hospital Association. Dr. Loeser is a specialist in internal medicine.

PHILOMENA I. LUCZEK, M.D., Solon, was elected president of the medical staff of Windsor Hospital in Chagrin Falls. Dr. Luczek is in private practice in Bedford. **HELMUT G. KRAMER, M.D.**, Aurora, was elected vice president. Dr. Kramer is in private practice in Chagrin Falls.

ALFRED H. MAGNESS, M.D., Coshocton, was appointed by the American College of Surgeons as local coordinator for the Coshocton County Memorial Hospital for the cancer program. Dr. Magness, a surgeon, has been chief of surgery the past 15 years at the hospital.

JORGE MEDINA, M.D., Willoughby, was elected president of the International College of Surgeons, United States Section. Dr. Medina is a thoracic surgeon.

JEFFREY B. MILLER, M.D., Massillon, was appointed instructor in internal medicine at Northeastern Ohio Universities College of Medicine. He will teach intensive care medicine. Dr. Miller is a pulmonary (lung) specialist on the medical staff at Massillon Community Hospital.

New officers of the medical staff of Fisher-Titus Memorial Hospital, Milan, are: **SHAN A. MOHAMMED, M.D.**, vice chief of staff, and **JAMES A. GOTTFRIED, M.D.**, secretary-treasurer.

The following were elected officers of Twin City Hospital medical staff: **BHARAT H. OZA, M.D.**, president; **JAMES Z. SCOTT, M.D.**, vice president; and **ROBERT J. KUBA, M.D.**, secretary-treasurer.

RALPH R. ROMAKER, M.D., New Lexington, was elected president of the Lancaster-Fairfield Community Hospital medical staff.

GREGORY M. SIDO, M.D., Toledo, and **DANIEL G. TANNER, M.D.**, Toledo, were appointed to the Flower Hospital-Crestview Center board of trustees. Dr. Sido is in private family practice and is former chief of staff at Flower Hospital. Dr. Tanner specializes in internal medicine and gastroenterology and presently serves as chief of staff at Flower Hospital.

New officers of the medical staff of Union Hospital, New Philadelphia, are: **CARLOS TORRENT, M.D.**, specialist in internal medicine, president; **ROY GEDULDIG, M.D.**, pediatrician, president-elect; and **PAUL W. McFADDEN, M.D.**, family practitioner, secretary-treasurer.

JAMES R. WILLIAMS, M.D., was named the new city health commissioner-medical director. Dr. Williams is a family practitioner in Niles.



a compilation of the latest developments, reports and products of interest to physicians.

edited by
Gina DiBlasio Cummins

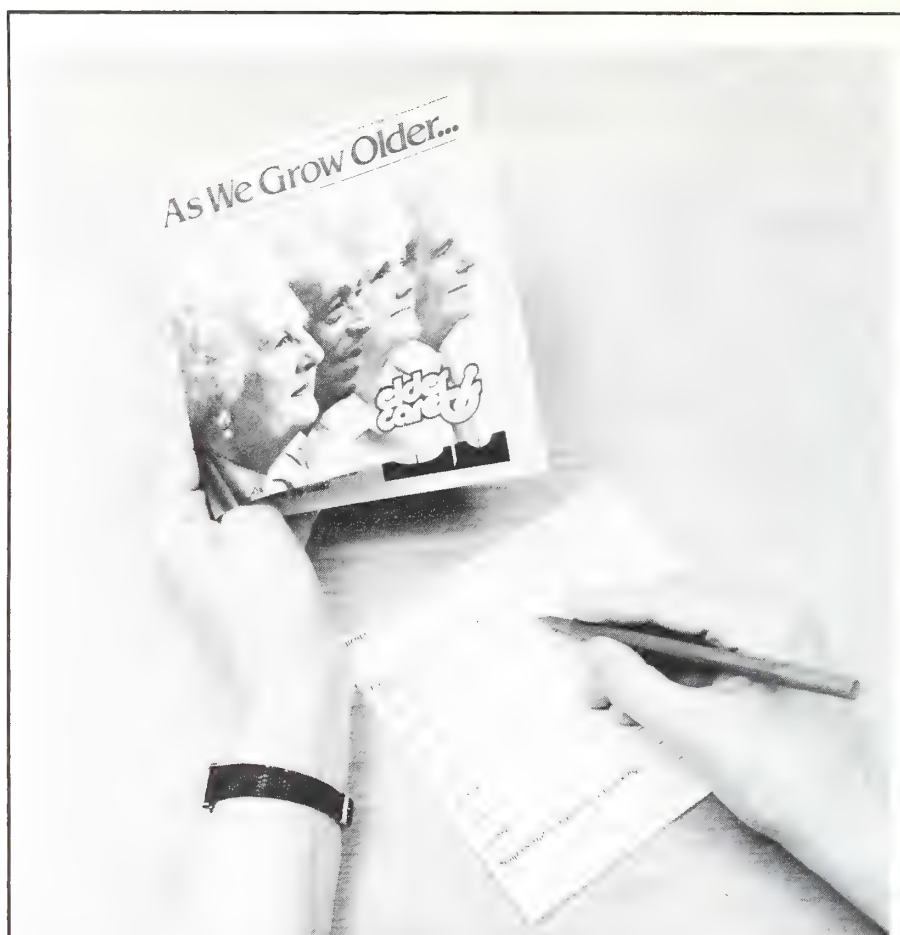


Claimants may assign awards directly to providers

Amendments to the Ohio Crime Victims Compensation Act now allow victims and their families to assign their awards directly to medical service providers, according to Attorney General Anthony J. Celebrezze, Jr.

The amendments permit the victim or claimant to assign voluntarily the payment for all or a part of an award for reparations for unreimbursed allowable expenses to the provider for injuries occurring on or after March 18, 1983, when medical charges exceed \$1,000.

For further information, contact the Attorney General's office, Crime Victims Compensation Section, 65 South Front Street, Columbus, Ohio 43215.



A helping hand . . .

Elder-Care assists patients in medication management

Parke-Davis is lending a helping hand to elderly patients. The company is introducing a program called Elder-Care that encourages older patients to ask health care practitioners for help in managing their medications.

As a first step, Parke-Davis has begun distributing materials to pharmacists, including a specially designed Elder-Care symbol and patient information booklets entitled "As We Grow Older."

Prepared by the University of Maryland School of Pharmacy, "As We Grow Older" tells what physical changes to expect with aging and that these might affect medications being taken. Patients are urged to talk openly with their physicians and pharmacists about their medication problems. Attached to the booklet is a card for the patient to keep track of

medications being taken. Store posters inviting patients to ask questions note that this is a service provided by the pharmacist to "help your doctor help your health."

"Although the medical problems that come with aging are well-documented, many of us have been so slow to accommodate the special needs of the elderly," said Joseph Dilger, director of professional relations for Parke-Davis.

A national campaign is planned to inform the public that those pharmacists who display the Elder-Care symbol are "ready, willing and able" to discuss proper medication usage, Mr. Dilger said, adding: "Parke-Davis hopes that Elder-Care will stimulate discussions between the elderly and their physicians and pharmacists."

No link between oral contraceptives and breast cancer

The most significant finding in a study conducted by the Centers of Disease Control is that no association appears to exist between the use of oral contraceptives and breast cancer. In addition, oral contraceptives appear to protect women against ovarian and endometrial cancer.

Other findings reported in a recent issue of the *Journal of the American Medical Association* include the following:

- Women with ovarian cancer are likely to be younger than 30, never been married or pregnant, and have a diagnosed infertility problem.
- Women with endometrial cancer (lining of the womb) are more likely to be older, white, obese, postmenopausal, and to have borne children.
- Women with breast cancer are more likely to have had children, been older when their first child was born, have a history of breast cancer in first-degree relatives (mothers, sisters), and a history of benign breast disease.

Hailing the news in an accompanying editorial, Barbara S. Hulka, M.D., M.P.H. says, "The importance of these studies lies in their large sample size, the geographic diversity of subjects, the inclusion of cancer cases from each area (eight cancer registry areas were studied) and the randomly selected population-based controls."

Not only were oral contraceptives cleared of suspicion with regard to the incidence of breast cancer, which affects 7% of American women sometime during their lives, they also were credited with lowering the incidence of endometrial and ovarian cancers, the third and fourth most prevalent cancers affecting women.

"Neither duration of oral contraceptive use nor time since first use altered a user's risk of breast cancer," CDC researchers say. "Women whose first use was more than 15 years ago and who used oral contraceptives for 11 years or more had a relative risk of 0.8."

The researchers were even more positive about the use of oral contraceptives in relation to the risk of ovarian cancer. From the eight cancer registry areas, 179 women aged 20 to 54, with diagnosed ovarian cancer, were enrolled in the study along with 1,642 controls.

Similarly positive results came from the study of endometrial cancer. Again, women in eight cancer registry areas were enrolled in the study, including 187 between the ages of 20 and 54, with diagnosed endometrial cancer and 1,320 controls.

"The protective effect occurred in women who had used combination

oral contraceptives for at least 12 months, and it persisted for at least 10 years after the cessation of oral contraceptive use," the CDC researchers say. "The protective effect was most notable for nulliparous (child-bearing) women. These results were not accounted for by differences between cases and controls in health status, parity, infertility, or other potentially confounding variables.

"We estimate that approximately 2,000 cases of endometrial cancer (39,000 were diagnosed in 1982) are averted each year by past and current oral contraceptive use among women in the United States," the researchers conclude.

MISCELLANEA

The National Commission on Certification of Physician's Assistants (NCCPA) has scheduled the 1983 Physician Assistant National Certifying Examination for October 12, 13, 14, and 15, 1983.

For eligibility information and/or individual applications, write: Registrar, NCCPA, 3384 Peachtree Road, N.E., Suite 560, Atlanta, Georgia 30326, telephone (404)261-1261. Accredited formal training programs will receive an ample supply of applications for their students directly from NCCPA.

The deadline for receipt of applications is June 30, 1983.

The Ohio Cancer Information Service (OCIS) has a new, easy to remember toll-free number — 1-800-4-CANCER.

The local office shares this easily recalled number with 20 other CIS

offices across the country, allowing callers to pass it on to out-of-state friends and relatives who will automatically be connected to the CIS office serving their area.

Cancer affects two of every three families, according to Nancy Kesselring Brant, director of the OCIS. "We are hopeful that this new number will increase public use of the service in Ohio by making it more accessible," says Ms. Brant. "We are sure there are people who would call if they knew we were here."

The CIS serves as a central source for referral to local service programs and as a contact point for information about the latest in cancer research. In addition to providing assistance over the telephone, the CIS office frequently offers free printed materials on subjects ranging from types of cancer and treatments to advice on how to talk with cancer patients.

cheap (chēp)

Defined by Webster's as "purchasable below the going price or the real value...depreciated in value...of inferior quality or worth...yielding small satisfaction."

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PICO is committed to accountability. Our audited financial statements are included in an annual report sent to all members of the OSMA. Claims data since the inception of the company is provided in our Loss Awareness Program, which has been viewed by more than 2,000 Ohio physicians in the past two years.

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The Rocking Chair Dilemma

By Karen S. Edwards

Americans are getting older. . . and not necessarily better.

Despite dramatic increases in life expectancy, those over the age of 65 in this country — the high-risk group — still are using three times as much medical care as those in younger age groups.

"By the year 2000, our population at risk will have doubled," says Robert H. Binstock, Ph.D., Director of the Policy Center on Aging at Brandeis University. Binstock was one of the featured speakers at the Ohio State Medical Association's (OSMA) Leadership conference last fall. "And that increase," he continues, "is bound to shake up the system of health care delivery and financing in this country."

The problem is that, presently, only a haphazard system of care exists for the elderly.

"There are simply too few physicians who are trained to deal with their needs," explains Binstock.

And, of course, their health care is not cheap. Binstock estimates that

more money currently is being spent on benefits for the elderly than on defense.

"The elderly are posing an unsustaining burden on society," he claims, and that burden is destined to

"There is every indication that more money is going to have to be spent on care for the elderly . . . but where will it come from?"

become even greater as, by the year 2000, 13.5 million people will become 75 years and older, and 3.2 million (12%) will turn 85 or older.

"There is every indication that more money is going to have to be spent on

care for the elderly — but there is nothing in the nature of our economy today that shows where this money will come from," Binstock says.

Certainly our society is not going to find much payment coming from the aged themselves.

"An elderly couple is considered to be out of the poverty level if they have \$5,498 annually. That allows \$17.62 for food each month, \$153 for shelter and \$76 for clothing, utilities, transportation and insurance, including medical and dental expenses."

There are four million elderly Americans who are currently just below this level and three million just above it.

"We aren't going to be able to squeeze much more money out of this group," Binstock says.

Of course, part of the reason for the high health care costs in this age group is the growing trend of institutionalizing the elderly.

continued on page 338

"The graying of the population goes on — without much money being spent on the biomedical research needed, the finances needed, the care that is needed . . ."

"Five percent of our elderly population is in nursing homes," Binstock says, then adds, "The trend is getting worse. Despite moves toward other alternate forms of care, no one is putting their money where their mouths are."

The problem he continues, is that the family's capacity to provide care is eroding. It used to be that institutionalization was turned to only when the family and the community could no longer cope with the aging individual.

"Until recently, families — usually daughters or daughters-in-law — provided 80% of the care for the elderly," Binstock says. "Now, however, 55% of today's women are in the labor force, and even if they want to provide care, they can't. Then too," he adds, "with the social trend of increasing divorce and remarriage, it's sometimes difficult to decide whose mother-in-law is whom's."

Biomedical research is going to add another dimension to the problem of aging Americans.

"The top items being researched today are heart disease, cancer and strokes. Now, if a cure for those is found in the coming years, that is going to put more people in the path of organic brain syndromes," Binstock says.

That means there is likely to be more and more people who will be robbed of the quality of their lives.

"Those with Alzheimer's disease and the other brain disorders may not even know about the care and love that is given them," Binstock says.

"The graying of the population goes on — without much money being spent on the biomedical research that is really needed, the finances that are

needed or the care that is needed."

And politically, there doesn't seem to be much likelihood for improvement.

"Older people are not a cohesive political force," Binstock says. "They have all sorts of identities, not just one. An organization of the aged simply do not swing the aged vote."

So what is likely to happen to health care delivery for the elderly in the future?

Binstock thinks that the government's number one concern will be cost containment, then that of equal access to equal quality care.

"Short term, there are bound to be ping-pong games between the federal and state governments, legislating help for this age group," Binstock says. "There could be HMOs for the elderly; an experiment with vouchers, perhaps; shopping for services. . ."

In essence, the federal government will be attempting to hold down public expenditures while demanding quality care.

"Cost containment legislation is probably going to be prevalent," Binstock concludes, but there will be some latent, ethical issues which will have to be faced along the way, as well.

"Complex issues will have to be weighed and traded off against each other," Binstock says.

For example, the Senate Committee on Aging found that a pacemaker costing \$800 is selling for \$4,000.

"Do items really have to cost that much?" Binstock asks.

Demands of adult, middle-income children will push for alternative systems of guilt-free, high quality medical care. Employers may look into providing benefits for those years



Robert Binstock, Ph.D.

beyond retirement.

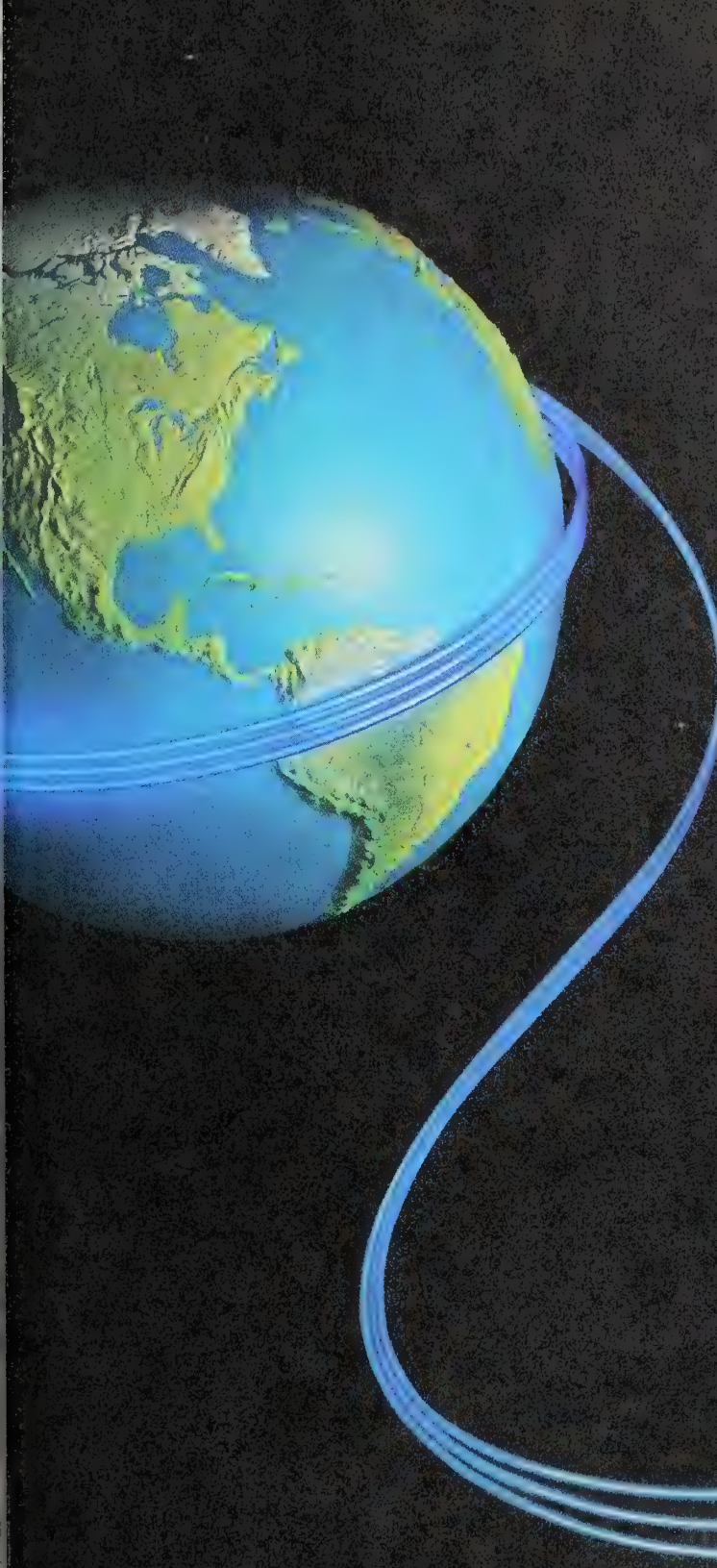
"We need supportive services for the elderly the same way that we need police and firemen," Binstock says. "Nationally, this kind of service is likely to be diluted, so it would have better luck if a system of this sort was supported locally."

The picture is not an uplifting one, Binstock admits, but the need for health care for the elderly is strong.

"We need to think about restructuring our whole health care delivery system," he says.

What about the physicians, themselves. How are they going to fit into this new continuum of care?

"In a leadership role," answers Binstock. "They must help their local communities develop more than symbolic care for the elderly." **OSMA**



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ONE
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Please see next page for brief summary of
prescribing information.

COMING SOON

ONCE-DAILY INDERAL[®] LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY

(For full prescribing information, see package circular.)

INDERAL[®] LA brand of PROPRANOLOL HYDROCHLORIDE

(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antianginal effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE.** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General. Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

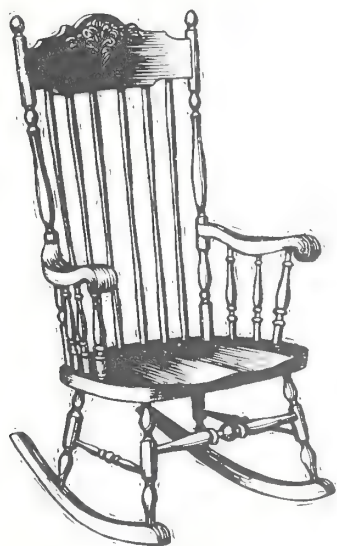
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSEAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories. **8520/583**

Ayerst. AYERST LABORATORIES
New York, N.Y. 10017



Old Age in Ohio

The “Rocking Chair Dilemma” at home

By Cary Kart, Ph.D.

Editor's Note:

To what extent does the “Rocking Chair Dilemma” exist in Ohio? The Journal asked a noted authority on aging, Cary S. Kart, Ph.D., to look into the types of problems that are — and will be — created by an aging population in this state.

The older population has been getting older and is expected to continue to do so. In Ohio, in 1980, the proportion of those who were 75 and over was 39.6% (and one in three of these people live alone). This figure should increase until about 2010 when those first born in the large post-World War II turn 65 and provide an influx of “young-old.”

The sex ratio of the Ohio older population is 65; that is, there are 65 older males in Ohio for every 100 older females. This is likely to remain stable into the 21st century. In part this results from the approximate eight-year advantage in life expectancy at birth females are likely to continue to maintain into the 21st century. According to biologist Leonard

Brief Prescribing Information

CONTRAINDICATIONS: Patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy, narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack

Hypersensitivity: Contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or phenanthrene derivatives

Nursing Mothers: Contraindicated because of the higher than usual risk for infants from sympathomimetic amines

WARNINGS: Use judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. May produce CNS stimulation and convulsions or cardiovascular collapse with accompanying hypotension

Use with caution in patients with increased intraocular pressure, cardiovascular disease, hypertension or in patients with a history of bronchial asthma. Do not exceed recommended dose

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reactions to sympathomimetics. Overdosage in this age group may cause hallucinations, convulsions, CNS depression and death

PRECAUTIONS: General Should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to epinephrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly

Information for Patients: Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children

Drug Interactions: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other CNS depressants may have an additive effect

Pregnancy Category C: Animal reproduction studies have not been conducted with NOVAFED A capsules. It is also not known whether NOVAFED A capsules can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. NOVAFED A capsules may be given to a pregnant woman only if clearly needed

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines

ADVERSE REACTIONS: Hyperreactive individuals may display epinephrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation. Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension

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OVERDOSAGE: Acute overdosage with NOVAFED A capsules may produce clinical signs of CNS stimulation and variable cardiovascular effects. Pressor amines should be used with great caution in the presence of pseudoephedrine. Patients with signs of stimulation should be treated conservatively

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It is difficult to be optimistic about the future provision of health care services to older Ohioans.

Hayflick, if we eliminate cardiovascular disease, stroke and cancer as causes of death, it would add about 18 years to present average life expectancy. Few expect the scientific or medical breakthroughs necessary to make this happen within the next 25 or 50 years. What is more likely is a modest three-year or so increase over the next 50 years with, perhaps, males and nonwhites benefiting most from such an increase.

It is difficult to be optimistic about the future provision of health care services to older Ohioans. Many have written that despite increased social visibility and increased levels of public funding in their behalf, there is ample evidence that some of today's aged, and particularly the chronically ill and disabled, have not been successful in securing appropriate health services. The current economic difficulties in Ohio would assure that elderly Ohioans are not immune to these problems. Many believe that the need for health services will increase dramatically in the future. The average older person is twice as likely as a younger person to suffer from one or more chronic conditions such as heart trouble or deafness; he or she also is more likely to be limited in activity, to be admitted to hospitals more frequently and for longer stays, and to use physicians' services to a greater extent. With an increasing elderly population, we can only expect that chronic illness and all it brings in terms of activity limitation, hospitalization, and increased use of physicians' services will become an even larger problem in Ohio as well as in the rest of the United States.

One solution to this problem of access to appropriate health services for older people would involve reorganizing the way medical services currently are delivered. Emphasis may

be on organizing a three-tier "system" that is concerned primarily with institutional services. The elderly are heavy users of institutional services and these services are most costly. While 5% of the elderly population is in institutions on any given day in Ohio, current data show that about one in four elderly persons will be institutionalized in a nursing or rest home for some period during their later years. This three-tier system would include the following forms of health service: (1) a community-based organization that provides a wide range of health care services to the elderly. The principal intention of this organization would be to prevent or delay institutionalization; (2) a second form, for the most part encompassing current nursing and rest homes, would be the community-based institution for those elderly who are incapacitated and require constant care; (3) the third component of this reorganization schema would be the hospice, established to provide care for dying persons and their families. Health service providing organizations representing each of these tiers currently are present in Ohio and some communities may have all three tiers represented. Still, in most communities, service provision has not been systematized and the important linkages between these organizations have not been generated.

Per capita health care expenditures for those 65 years of age and older are about two and one half times those for other adults. Yet the elderly are, on the average, considerably poorer than other adults. The average income of an Ohio household headed by a person 65 years or older is about 60% of the income of all Ohio families. Still, while only 7% of Ohio households headed by an aged person had 1979 income below the poverty level, 28% of aged

persons living alone had income below the 1979 poverty level. Medicare and Medicaid have been of some help. About two thirds of the total health care bill for the elderly is paid out of public funds, primarily from these two programs. Still, these programs also have been implicated in increasing the costs of health service delivery. And, the state's current economic woes have caused it to look more carefully at the level of state reimbursement Ohioans can afford under Medicaid.

Though some look to the federal government for help in financing health care services through some form of health or catastrophic illness insurance plan, this seems unlikely. Such proposals, including the President's recent proposal for catastrophic illness insurance, end up simply reorganizing the payment structure. New proposals should be more than innovative schemes for altering the payment plan for health care. If the elderly in this state are to benefit in the future, proponents must assure that any plan adopted guarantees the availability of and accessibility to a wide array of comprehensive health care services, including those dealing with prevention and maintenance as well as those providing acute and chronic care. And here's where leadership by the medical establishment in Ohio and other states must take hold. While many internists and family practitioners have elderly patients, only a small number of physicians in this state (and this country) would describe themselves as Practicing geriatric medicine. Traditionally, the specialty of geriatrics has lacked prestige and has been seen by prospective physicians as an area not rewarding to work in. Some believe these attitudes are changing. Surveys

continued on page 345

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Old Age in Ohio

continued

of medical school students suggest that many of them desire course content and clinical experiences in geriatrics. Leslie Libow, of New York's Mount Sinai School of Medicine, recommends a department of geriatrics in every medical school and hospital.

Geriatrics is a field that will continue to grow if only to keep pace with growing numbers of elderly. Funding for training and research must be improved and better directed. And this is the case not just for biomedical research and the training of more geriatricians, but across all disciplines. I read recently that there have been only about 1,000 Ph.D. dissertations in gerontology since 1930. Every area

needs more support. Promising areas of biomedical research include "senility," and nutrition and aging. Social scientists are interested in issues such as the relationship between retirement and migration. What is the

Geriatrics is a field that will continue to grow, if only to keep pace with growing numbers of elderly

impact upon communities to which older people are retiring? More

importantly for Ohio, what is the impact upon the communities from which older people are moving? **OSMA**

*Dr. Kart is a professor and chairman of the Department of Sociology, Anthropology and Social Work at the University of Toledo, and is a prolific writer on the subject of aging. His most major works include his books **Aging and Health** (with Metress and Metress), and **The Realities of Aging**. Dr. Kart currently is working on another book, **Nutrition, the Aged and Society**, with colleague Seamus Metress, Ph.D.*

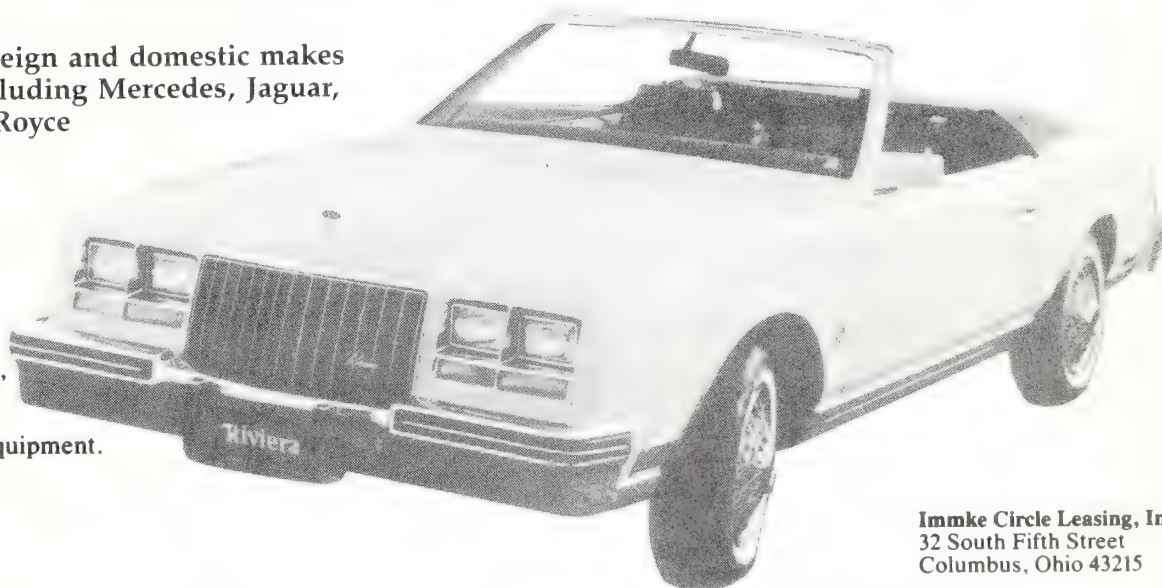
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Home, CROWDED Home

By Karen S. Edwards

"The odds are one in four that you will be institutionalized sometime before you die."

—Robert H. Binstock, Ph.D.
Director, Policy Center on Aging
Brandeis University

Odds like the ones Dr. Binstock tosses around are disquieting at best, but in light of current available statistics on Ohio's increasing elderly population, those odds suddenly take on a whole new meaning.

Consider that, by the year 2005, there are estimated to be 1,440,085 Ohio residents over the age of 65. Even more alarming is the 687,346 Ohio residents who will be over the age of 75. If Dr. Binstock's projections prove to be true... where will all those elderly patients in need of institutionalizing go? And, more importantly, how will they be supported?

"There's no doubt that these questions are going to have to be addressed soon," says E. Jayne Moser, State Nursing Home Ombudsman, Ohio Commission on Aging, "but I think you already are seeing some developments in this area, and there are bound to be more in the future."

Surprisingly, Moser sees a slowdown in the growth of nursing homes.

"I think you will see more retirement communities, and more middle income housing, financed by the private sector," she says, and her reasoning is quite valid.

After all, private investors who have long since been building and funding the retirement communities, can't help but see the tremendous growth potential in the aging market. And it is quite likely that some will be investing in middle income housing — in much the same manner that the federal government now is providing low-cost housing for the elderly.

"Not everyone will be in a financial position to enter a retirement community," explains Moser, an act that generally requires a substantial sum of upfront money. Those who cannot (or will not) provide the necessary "investment" — and who are still capable of providing their own

care — may opt instead for housing which is subsidized by the government (or a private sector) and for which they pay a small rental fee.

"Today, the elderly in public housing facilities are paying a rent that is approximately 25% of their income," says Moser, "and the federal government supplements the rest."

Other alternatives will be explored too, Moser claims.

"Many alternatives to institutionalization already exist," says Moser, "but they often are not developed at the community level," she says.

Karen Crosman, who works in the area of Health Services for the Ohio Commission on Aging, outlines some of the existing possibilities.

"There is adult foster care, where care for the elderly is provided in private homes. Shared housing, where the elderly live together under the care of a resident manager, is another



possibility, and day care for adults is another up and coming alternative," she says.

In fact, the day care alternative seems to be one of the most viable, in terms of today's labor force. Elsewhere in this issue, Dr. Binstock says that the reason most of today's elderly are institutionalized is because there is simply no one left at home during the day to take care of them. (See "The Rocking Chair Dilemma," pg. 337.)

"The day care program provides minimal medical and social supervision for the elderly," Crosman explains, "so that the family or spouse who is employed during the day, but who still wants to keep the elderly relative at home may do so."

Moser adds that this kind of alternative is likely to be further developed in the future by nursing homes, retirement communities and perhaps even hospitals.

"These types of facilities lend themselves easily to providing this kind of care," Moser says.

The government, too, will be launching its own investigation into nursing home alternatives, and in fact, Congress now is considering an Act which will allow Medicaid funds to be used to financially support the elderly patient at home.

Why all this emphasis on nursing home alternatives? The cost factor, of course.

"Every year, the State of Ohio spends \$40 million on nursing home care for the elderly," says Moser, and that translates into a lot of Medicaid/Medicare benefits.

But it is often those benefits which are responsible for a whole new set of problems.

"The system itself is confusing, and not always readily understood by physicians or other health care professionals," says Crosman.

Often, patients and physicians will have to wade through pages of bureaucratic terminology before they can understand what kind of care their benefits provide. And then they run into a sort of "Catch 22."

"Most of the elderly population receives Medicare benefits, but not Medicaid," Moser explains.

Medicaid is the medical assistance program administered by the Welfare Department, while Medicare is the federal insurance program available to most people 65 years and older.

"The problem begins with the Medicare program which, because of various conditions that must be met,

"A number of older people are placed into homes because they are incompetent or incontinent and their relatives don't want to deal with it anymore."

actually pays for a very small percentage of nursing home costs," Moser continues.

Medicaid, however, generally pays the entire bill, with the state assuming 45% of the costs, and the federal government picking up the rest.

Now comes the "catch." As mentioned earlier, few elderly patients qualify for Medicaid assistance, so they enter a nursing home with only their Medicare benefits to help them pay the way. However, if the patient is ill enough, he/she can go right through their Medicare benefits, as well as their own personal finances until,

finally, they reach a stage where they are qualified for Medicaid.

"We've created a system which gives a patient no room to float in and out. Once they're in. . .they're in," Moser says.

Ohio, however, has begun to address some of these problems. A Long-Term Care Council, consisting of nine separate state agencies (Welfare, the Department of Health, The Ohio Commission on Aging and the Department of Budget and Management, to name a few) meets several times a year for the purpose of formulating some kind of state policy in this area.

Several suggestions already have been made: tax incentives or a cash supplement could be provided to those who provide care for elderly family members in their own home, for example.

"And we've also suggested a type of preadmission screening, similar to a system which is working well in Virginia and Massachusetts," Crosman says.

Under this system, those patients recommended for nursing home care would be assessed as to their condition and their needs. If possible, they would be routed on to an alternative type of care.

"It seems that a number of older people are placed into nursing homes because they are incompetent or incontinent," Moser says. "Their relatives just don't want to have to deal with it anymore."

Nursing home care may not be the best alternative for these patients, but in many communities, it may be the only alternative.

"We may find that hospitals will become more flexible in providing care; we may see more emphasis on medical intervention. We may see more research being conducted into

continued on next page

Home, Crowded Home

continued



Alzheimer's disease and dementia, and into the whole area of geriatrics, so that we may know how to better prepare ourselves for the aging process. And, we may see more pressure being placed on communities to provide alternatives to nursing home care to save state dollars," Moser says.

The bottom line is that the state doesn't want the patient to pay for a higher level of care than he/she may need.

"I think the important thing is that the state is aware of the problems in this area, and it is attempting to address them with a single voice, rather than letting each agency handle

the problems in its own way," Crosman says.

"We need to let physicians know that geriatrics is going to be a vital specialty in the near future — and we need to make them aware of the need for alternatives to nursing homes," Moser says.

"Physicians can play such an influential role in developing geriatric programs in their own communities," she concludes, "and we hope they do." **OSMA**

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal

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Who You Can Turn To

If you are interested in obtaining further information about care for the elderly, you may wish to contact the following organizations:

- **The National Institute on Aging
Department of Health and Human
Services**

**National Institute of Health
Bethesda, Maryland 20205**

- **Society of Geriatric Ophthalmology
c/o Frank Weinstock, M.D., President
214 Dartmouth Avenue
Canton, Ohio 44710**

Disseminates information on the ophthalmologic concerns of the aging population to ophthalmologists as well as the general public; and stimulates research in this field.

- **The Gerontological Society
1835 K Street, N.W., Suite 305
Washington, D.C.**

- **The American Geriatrics Society
10 Columbus Circle
New York, N.Y. 10019**

Conducts continuing education programs; encourages interest in geriatrics among medical school students; disseminates current information in the field; defines areas of needed research in the clinical care of the elderly.

- **The Ohio Commission on Aging
50 West Broad Street
9th Floor
Columbus, Ohio 43215**

Provides information about Ohio nursing homes, and other Ohio geriatric programs. Statistics also are available on Ohio's elderly population.

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Geriatrics:



Our Profession's Newest Responsibility

By Roy L. Donnerberg, M.D.

As the elderly population increases, every physician becomes, in essence, a geriatrician. Are you ready to assume the new responsibility these patients are going to mean to your practice?

Think old. Then, think older. Recently released demographic projections by the Ohio Commission on Aging bring this concept into focus. The 65-plus population of our State will increase by more than 20,000 annually. It is now generally known that the over-65 persons currently constitute 11% of our population with predictions expected to increase that figure to over 18% (nearly one of every five) in 40 to 50 years. What generally is not appreciated is the large number of the very old there will be within this population in the very near future. From 1970 to 1980, the over-85 population in our State grew some 38%. Within 10 to 15 years, the 65 to 74 population in Ohio will increase in number by 140,000 persons to a total of 840,000. Even more important, the over-75 population will grow from a total of 460,000 in 1980 to 687,000 by the year 2005. By 1995, the over 75 to 84 population will increase by 20% and

the over 85 population by 60%. In Ohio there are already 1,300 individuals over age 100 and over 200 people over the age 110. So don't *just* think old and older. Think, too, in big numbers.

There is every indication that this very old patient population will require considerable time and effort from physicians in the future—as well as from other health care personnel. Presently, approximately 40% of a physician's time is involved with caring for over-65 patients. It is predicted that in 40 years, this population will require over 70% of all physicians' patient care activities. Some of these professional responsibilities will increase simply because of the sheer number of elderly patients we will be seeing. But consider too, the impairments and fragility of the old elderly. Their losses of functions and system reserves come about from a combination of senescence and multiple diseases. Cells progress through an embryonic stage (growth and increase in function), a period of maturity (prime function and little change) and inevitably, senescence — a period of genetically determined loss of cellular, organ and body system functions. Consider the loss of muscle mass and general weakness of the very old, the time dependent reduction of nephrons, the loss of lung, skin and arterial wall elasticity, just to name a few. Consider osteoporosis. In 1980, there were over 200,000 bone fractures in the elderly in this country with a mortality varying from 5% to 30% depending on location and age group. With this, there is also frequent disability and impairments and an estimated medical expense of over \$1 billion.

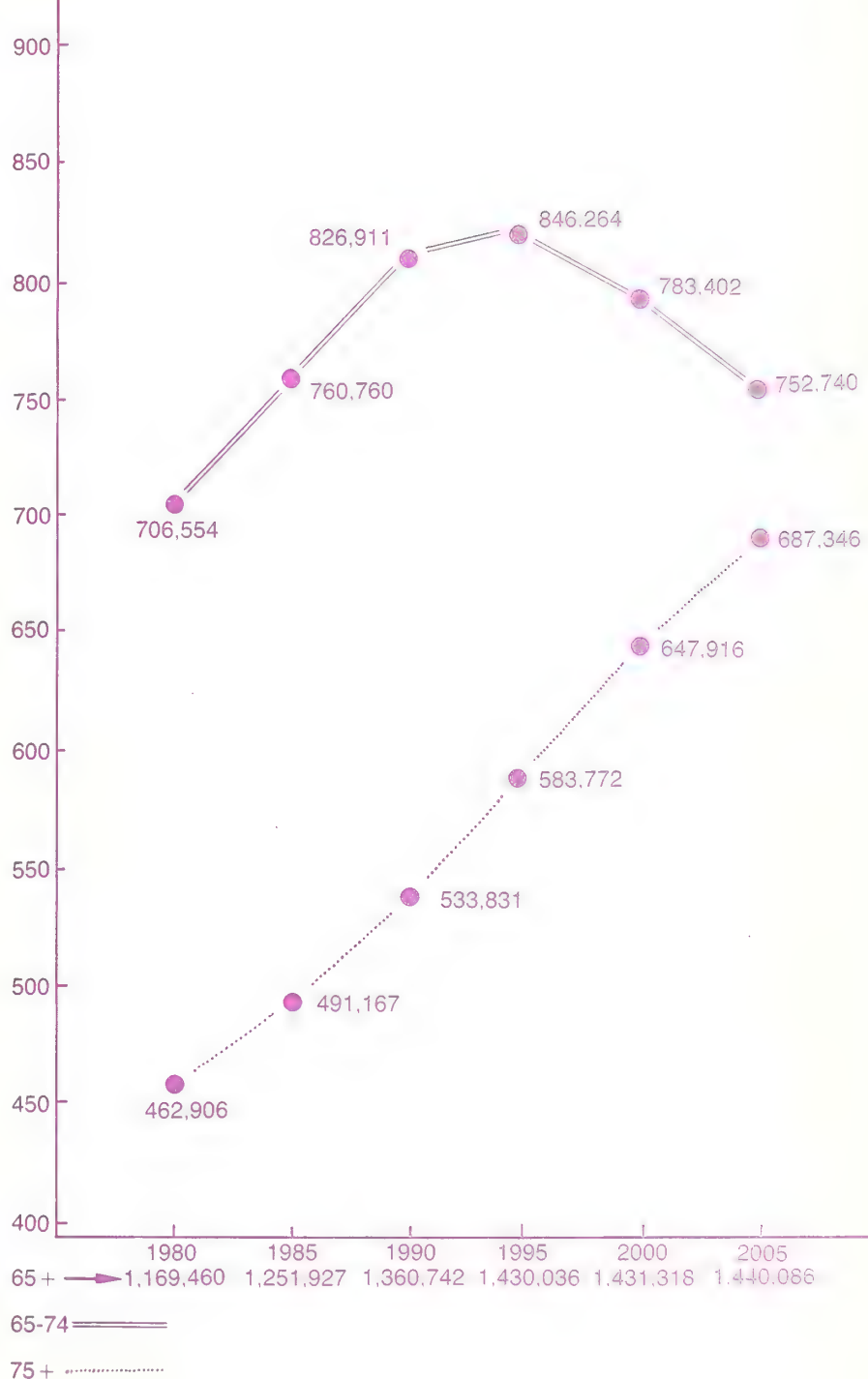
Dementia, one of the most devastating and dehumanizing illnesses, occurs in serious stages in 5% to 10% of the over-65 and 20% of the over-80 population. Five percent to 10% of the over-65 population, and 20% of the over-80 population require almost total care in our nursing

POPULATION PROJECTIONS

(In Thousands)

1980-2005

Older Ohioans



OCOA/PERT 10-82

Graph is courtesy of the Ohio Commission on Aging. Source: U.S. Census Bureau and Ohio Department of Development.

homes. Most of the over-80 patients have serious limitations of mobility. Most of our elderly have more than one chronic disease. They compromise 11% of our population and require 25% to 30% of our health care dollar.

These very old people have a body physiology different from youth and maturity. Documentation of these age-dependent and senescent-related alterations of body function is accumulating. It is a significant body of knowledge at the present and it is growing rapidly. Diseases in the very old frequently occur with unique symptoms and signs. The pathophysiology of the disease process is superimposed or modified by organ physiology of senescence. Organ and

Diseases in the very old frequently occur with unique symptoms and signs . . .

system reserves frequently are compromised. Diagnosis, procedures and therapy may be quite different because of age-related changes. Clinical strategies differ because of the great influence of life style, nonreversibility and limited curability of diseases requiring a clinical expertise only produced by experience and involvement with the totality of the elderly patient's life. The traditional ingredients of a special health care need and a medical specialty can be recognized easily.

Beyond these professional requirements of a special health care lies the importance of the psychosocial needs of the elderly, so fundamental to the health care of the very old and yet so frequently overlooked by those in the contemporary medical practice of mature adults with single diseases. Contemporary medicine should, indeed, be practiced at the

continued on page 383

Aging

The disease that research almost forgot

There is now a serious pressing need to stimulate and encourage support of biologic and biomedical research related to human senescence and the diseases of the aged. Basic research into the biology, pathobiology, physiology and pathophysiology of age-dependent alterations in body, organ and system function will be the basis for a new approach to helping the elderly. Research into dementia surely will provide better and more productive answers for the care of demented patients than the construction of more nursing home beds. Research into the biologic alterations and beneficial therapeutic modifications of osteoporosis will do more to decrease the suffering and death from hip fractures than improvements in surgical techniques, although this too will need research.

The National Heart, Lung and Blood Institutes and the National Institutes for Neurological Diseases and Blindness and many other of the national institutes, have financed many projects related to the aging process. The National Institute on Aging was formed and has grown under the leadership of Dr. Robert Butler and now under the direction of Dr. T. Franklin Williams. This has resulted in additional funds and activities in aging research. The budget is limited and in 1982 was \$81 million compared to \$943 million for cancer and \$559 million for cardiovascular research. Federal support for needed expansion comes at a time of budgetary constraints.

In 1978, Dr. Robert Butler, Director of the National Institute on Aging, requested Dr. Irving Wright to initiate the formation of an Association similar to the American Heart Association, to

encourage and support aging research. These were the events leading to the beginning of the American Federation for Aging Research, Inc. (AFAR). AFAR now is established on a national basis. The national organization has a membership which includes distinguished and respected scientists and lay people. Aging related research has already been funded. The national office of AFAR is established and growing rapidly.

Ohio is fortunate in being the first geographic Affiliate of AFAR. Interested and dedicated Advisory Council members, meeting monthly for over two years, have drawn up a charter, obtained tax exemption status and mapped plans for growth. The Advisory Council members include distinguished citizens and scientists interested in aging research. The Ohio Affiliate of AFAR has been incorporated as a not for profit corporation within the State of Ohio. It is under contract with the national office of AFAR as the Ohio Affiliate. The objectives of AFAR-OA are to educate the public about senescence and aging and allow mechanisms for the public to support biologic research of the aging processes and biomedical research of the pathophysiology of aging and the diseases of the aged.

From this modest beginning, AFAR-OA now plans to enlist the involvement of interested Ohioans in this worthy effort to help our elderly.

For further information on this group, contact:

Roy L. Donnerberg, M.D., President
American Federation for Aging
Research-Ohio Affiliate, Inc.
Martin Janis Center
600 East 11th Avenue
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USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic-M is not recommended for patients 12 years of age and under.

PRECAUTIONS: ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics. MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS: ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus. MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. GI: Nausea, vomiting, diarrhea. CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carboprost, and cross-sensitivity between meprobamate, meprobamate and meprobamate-carboprost. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and

bullous dermatitis have occurred. **HEMATOLOGIC (SEE ALSO ALLERGIC OR IDIOSYNCRATIC):** Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE: Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdose produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS: 0.5-2.0 mg percent represents usual blood-level range after therapeutic doses. The level may occasionally be as high as 3 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur. At levels greater than 20 mg percent, more fatalities than survivals can be expected. Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator. In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED: Bottles of 50 scored tablets.

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The Aging of America



Who Will Take Care of Me?

By Gina DiBlasio Cummins

From the moment of conception and throughout the majority of our lives, there are numerous physicians to take care of us. An obstetrician monitors our growth in the womb until our entrance into the world. We then rely on a pediatrician to safely guide us through our childhood years. As adults, we seek the services of a general practitioner until a specific problem requires the need of a specialist.

Therefore, we understandably wonder who will be there to look after us during the "golden years" — the time when many of us require specialized attention for the physical and mental problems that accompany old age. In the past, geriatricians traditionally have handled the problems associated with the elderly. Today, however, thanks to medical progress many of us are living longer — causing the gap between the number of existing geriatricians and

the increasing elderly population to grow wider and wider. So wide, in fact, that the increasing elderly growth is fast becoming one of society's major medical, social and legal problems.

"In 1978, Ohio passed significant legislation to address this problem," says Mike Tootell, administrator of health programs, Ohio Board of Regents. "Its passage made possible the establishment of offices of geriatric medicine at each of the Ohio medical schools (supported by the State); furthered development of postgraduate programs in geriatrics; and provided for a study of needs in this area.

Tootell notes that since the legislation was passed, Ohio has distributed approximately \$1 million per year among the seven Ohio medical schools to fund these programs. This is significant since Ohio has one of the few, if any, state-subsidized programs in the United States. Before these programs are

Who Will Take Care of Me?

continued

offered, they are reviewed and approved by the State Gerontology Advisory Committee, chaired by Amasa B. Ford, M.D., Associate Dean for Geriatric Medicine at Case Western Reserve. The Committee meets to evaluate existing programs as well as to assist in developing new ones.

There is no question that the establishment of these medical school programs has accomplished what it intended — to increase the medical student's awareness and exposure to the problems of the aged. Although this is a giant step in the right direction, it isn't enough to motivate and adequately prepare enough physicians to care for the tremendous growth of the elderly. Ohio needs more gerontologists and perhaps Ohio medical schools will need to concentrate their efforts on recruiting more students to this field.

Fortunately, Ohio has recognized the problems of caring for a rapidly increasing elderly population and has taken the lead in trying to find a solution. Still, it has a long way to go before it can honestly answer the elderly's question, "Who will take care of us?"

A LOOK AT OHIO MEDICAL SCHOOL PROGRAMS:

Since passage of the 1978 bill, the seven Ohio medical schools have focused on providing their students with exposure to geriatric medicine. Although the programs at each school vary somewhat, their purpose remains the same — to make future physicians aware of and able to care for the problems of the aged.

• Case Western Reserve School of Medicine

Medical school representative on geriatric medicine: Amasa B. Ford, M.D., Associate Dean for Geriatric Medicine

According to Chris Hayward, associate director, Case has tailored its medical school curriculum to give undergraduate and graduate students increased exposure to the problems of the aged. During a medical student's first two preclinical years, he/she is exposed to several medical courses which feature an emphasis on geriatrics. During the last two years, students have geriatric clinical

experience options in addition to some required experiences in geriatric studies.

"These clerkships provide valuable on-site training and exposure to the elderly," says Hayward. She notes that Cleveland has several fine clerkship sites where students can train. The University Hospital's Center for the Care and Assessment of the Elderly, Cleveland Metropolitan General/Highland View Hospital's Medical Unit for the Elderly, several outpatient services and various geriatric counseling firms are among the sites available. In addition, Case is developing clinical sites and clinical faculty to create model units for the care of the elderly.

Hayward adds that in order to make existing physicians aware of and able to deal with the increasing problems of the elderly, Case has sponsored several continuing medical education courses and lectures on the problems of the aged. "A year ago we offered intensive faculty development courses on the medical management of the aged and we periodically sponsor lectures on geriatrics which feature



Since the legislation was passed, Ohio has distributed approximately \$1 million per year among the seven Ohio medical schools.

Mike Tootell discusses geriatric programs available at Ohio's medical schools.

national and international experts on geriatric medicine."

• University of Cincinnati Medical Center

Medical school representative on geriatric medicine: Bruce Bosmann, M.D., Associate Dean

Dr. Bosmann feels that the legislation passed in 1978 was only the first step in dealing with the rapidly increasing elderly population. While exposing more medical students to geriatrics is helpful, he feels that an effort must be made to recruit students in this field.

Dr. Bosmann says that medical students at the University of Cincinnati Medical Center are exposed to a total of 58 hours of geriatric material over a four-year period. In addition, the school offers a strong residency program in both family medicine and geropsychology.

The school also has a particularly impressive preclinical and clinical research program which focuses on the special care needed when dealing with a geriatric patient.

Dr. Bosmann notes that the school is developing a geriatric assessment team including geriatricians, geropsychologists and neurologists to assess and evaluate an elderly patient's physical and emotional condition. He hopes to expand this program to include clergy, lawyers, family and medical students. "Our aim is to treat not only the elderly's diseases, but to treat the individual as a whole — physically, mentally and emotionally. Dr. Bosmann feels that by learning to assess the total individual, medical students will become more sensitive to the needs of the elderly and their families, and may thereafter be more qualified to recommend treatment.

He applauds Ohio's decision to fund these geriatric programs and for taking the lead in solving the problems of caring for the elderly population growth. He says that since the State

has set an example by finding these programs, other individuals are encouraged to do so as well. In fact, Dr. Bosmann is the first professor to hold the Martha Betty Semmons Chair of Geriatrics which guarantees that the University of Cincinnati will have someone representing and advocating geriatrics permanently.

• Ohio State University School of Medicine

Medical school representative on geriatric medicine: Leopold Liss, M.D., Professor of Pathology

Dr. Liss says that Ohio State's medical school includes geriatric programs in its basic education curriculum, as well as in continuing education and community courses.

Ohio State medical students are exposed to several lectures on geriatric medicine during their first year. They also have the opportunity for on-site experience with both healthy and impaired elderly in the community. Elective clerkships on geriatric medicine are available to students with a strong interest in working with the elderly.

The school also provides ongoing continuing education programs which

held in April, was sponsored in conjunction with the Alzheimer's Disease Association.

The Office of Geriatrics also has established a Community Advisory Board, comprised of people from all walks of life, who are concerned with the elderly. "All our plans and activities are presented to them first for discussion and recommendation."

Dr. Liss is looking forward to 1985 when a new Geriatric Center should be completed at Ohio State, which will become the University's home for geriatric clinical, research, and administrative activities.

• Medical College of Ohio

Medical school representative on geriatric studies: John McGreevey, M.D., Assistant Professor, Department of Medicine

Dr. McGreevey says that the Medical College of Ohio's tactic is to train all primary care students in geriatrics rather than recruit geriatric specialists.

He explains that all medical students at the school are exposed to a lecture series on geriatric medicine. In addition, the school has required rotation in ambulatory medicine for all residents in internal medicine. This rotation aims to expose the residents

The Medical College of Ohio's tactic is to train all primary care students in geriatrics rather than recruit geriatric specialists.

feature a series of in-house lectures on specific geriatric problems, aimed at physicians in training, medical students and doctoral candidates.

In addition, the school offers practicing physicians approximately four continuing education courses per year on various geriatric problems such as skin care, nutrition and dementia. The most recent course,

to a geriatric experience, such as working in a nursing home or outpatient clinic. In addition, there is a more intensive elective rotation opportunity which focuses on geriatrics and is available to both students and residents. Dr. McGreevey notes that the family practice programs also include some clinical exposure in geriatrics.

Who Will Take Care of Me?

continued

Dr. McGreevey regularly speaks at continuing education courses on subjects such as dementia and drug therapy to make practicing physicians more aware of the increasing elderly population and their problems.

• Northeastern Ohio Universities College of Medicine

Medical School representative on geriatric medicine: Chris Marquart M.D., Acting Director, Office of Geriatric Medicine and Gerontology

Dr. Marquart says that in order to expose all medical students to geriatrics, the school has incorporated a combination of gerontology and geriatric medicine in most courses at the medical school. "Our philosophy is that we do not need a geriatric specialty as much as we need to upgrade the training of all physicians in the various areas of geriatrics."

The school concentrates on exposing students to geriatrics in a positive manner. "Our medical students receive on-site experience by working with healthy older people in an ambulatory-care setting." He feels that if students are exposed to healthy elderly patients, they will be more encouraged to work with them.

• Wright State University

Medical school representative on geriatric medicine: Joseph D. Alter, M.D., M.P.H.

Dr. Alter says that Wright State's emphasis is on training and enlightening students, faculty, and community physicians in geriatric medicine.

Medical students are offered two weeks of electives during the first two years on the care of the elderly, including on-site training and basic classroom instruction. There is also a one-month selective on aging, offered during the fourth year. Students in family practice are required to take 25 hours in geriatrics and a 3rd year

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA* (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



Quotes from an unsolicited
letter received by Pfizer from an
angina patient. While this patient's experience
is representative of many
unsolicited comments received,
not all patients will respond to
Procordia, nor will they all
respond to the same degree.

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for the varied faces of angina

*Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

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Please see PROCARDIA brief summary on adjoining page



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Who Will Take Care of Me?

continued

clerkship in the area.

The school's continuing medical education is geared to both faculty and practicing physicians in the community through periodic workshops which focus on the care of the elderly.

Finally, Dr. Alter would like to develop a clinical research program, but his numerous attempts to obtain funding have failed. He hopes to obtain monies in the future for what he believes would be a valuable program and asset to the school.

• Ohio University College of Osteopathic Medicine

Medical school representative on geriatric medicine: Charles J. Cannon, D.O., Head, Section of Geriatric Medicine and Gerontology

Dr. Cannon says that he has been encouraged the last four to five years

since there has been enough money to fund the school's programs.

"However, I'm worried that unless we receive more funding, all the good we have done thus far will be severely limited."

He explains that the school requires all medical students have 44 hours of exposure to geriatrics. "Of the 44 hours, 12 deal strictly with geriatrics, 15 to 25 hours are spent actually working with the elderly, and the remaining hours are in courses which are closely related to geriatrics."

During the last two years, students are free to choose electives consisting of two weeks of varied geriatric duties in clinics, nursing homes or a hospital setting. As part of the curriculum, a student also becomes involved in assessing the elderly in their homes as well as at the senior center. "This assessment program is an important tool since it affords students the

opportunity to learn how elderly patients function in the home environment economically, socially, physically and mentally. "We think that a student is more prepared and able to treat the elderly if he understands all facets of the patient's situation."

The school also has sponsored and cosponsored many continuing education seminars on the aged by working with community groups such as the senior center in Athens, the Hospice organization and Alzheimer's group. **OSMA**

Gina DiBlasio Cummins is a staff writer for the Ohio State Medical Journal and the editor of Synergy.



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Care of the Elderly

The hospital's changing role

By Charity Elefterin

How are hospitals going to meet the needs of an increasing number of geriatric patients? One hospital has already stepped back to examine its changing role with regard to elderly patients.

By the year 2000, Ohio's 65 and older population will increase by almost 21%—3% more than those in the 40 to 64 age group. By 2030, when the baby boom generation has reached elderly status, a gaping discrepancy between the numbers of young and old will exist.

This phenomenon, together with an increase in acute and chronic disorders, a floundering economy and subsequent cutbacks in third-party reimbursements are placing an increasingly weighty burden on hospitals, monetarily and in terms of bed capacity.

Perhaps more disturbing is the still common ignorance of these trends and the laggardly pace at which geriatric education is becoming available to physicians, nurses, other health care professionals and students of these disciplines.

To escape the consequences of this rapidly gaining influx, hospitals must redefine their roles in caring for the elderly, set new goals and begin reaching for them.

Basic objectives that some hospitals have begun to meet including Aultman Hospital in Canton, include reducing the geriatric patient's average length of stay in the hospital and reducing the proportion of elderly inpatients.

Release from the hospital is contingent on healing or, in the case of the geriatric patient, the highest level of healing attainable. To reach this level, doctors, nurses and all

Your Angina patients could fly coast to coast on the long-acting effects of one 10mg tablet.

Bioavailability findings* of Oral, Sublingual and Chewable Cardilate® dosage forms in volunteers demonstrated that the Oral (swallowed) 10mg Tablet provided a 6-hour duration of pharmacologic effect; more than 3 times longer than when given sublingually, or as the chewable Tablet. Cardilate Oral Tablets are recommended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris.

*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythryl Tetranitrate Bioavailability. *Clin Pharmacol and Ther* 29:35-39, 1981.

Cardilate® (erythryl tetranitrate) Tablets

INDICATIONS: Cardilate (Erythryl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin

CONTRAINDICATIONS: Hypersensitivity or idiosyncratic reaction to organic nitrates.

WARNINGS: The use of nitrates in acute myocardial infarction or congestive heart failure should be undertaken only under close clinical observation and / or in conjunction with hemodynamic monitoring.

PRECAUTIONS: Use with caution in patients with severe liver or renal disease. Tolerance to this drug, and cross-tolerance to other nitrates, may occur. Cardilate should be given to a pregnant woman only if clearly needed. Caution should be exercised when Cardilate is administered to a nursing woman. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: The most frequent adverse reaction in patients treated with Cardilate is headache. Other adverse reactions occurring are the following: cutaneous vasodilatation with flushing, and transient episodes of dizziness and weakness, plus other signs of cerebral ischemia associated with postural hypotension. Occasional individuals exhibit marked sensitivity to the hypotensive effects of organic nitrates, and severe responses (e.g., nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and / or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION: Oral / Sublingual Tablets: Cardilate (Erythryl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg, prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED: TABLETS (Scored) for ORAL or SUBLINGUAL USE
5 mg: Bottle of 100, 10 mg, Bottles of 100 and 1000

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professionals involved in the care of elderly patients must attune themselves to the special, complex problems that characterize them.

Most are victims of multiple diseases, undergoing multiple therapies and taking a variety of medications. The effects of interactions among the diseases, treatments and drugs largely are not understood and are frequently complicating.

Varying degrees of Alzheimer's disease and the trauma of hospitalization itself often result in anxiety and depressed psychophysiologic functioning such as confusion, incontinence and failure to eat.

Intimidated by "ageism" (societal prejudice toward old people), the geriatric patient often feels powerless to communicate even the details of his own case with physicians who may or may not possess the prejudice.

This and the fact that diseases sometimes manifest themselves differently from older to younger patients make it difficult for doctors to diagnose, let alone treat the geriatric patient effectively.

Improvement through education of the approaches and skills of staff in caring for the elderly could remove some stumbling blocks from the road to better healing and shorter hospital stays.

J. David Marler, Ph.D., director of medical education at Aultman, says "There is a definite recognition here of the need for more in geriatric training. We are receiving more and more grant proposals for such programs, and more of them are being conducted."

At Canton's Aultman Hospital, the Department of Anesthesia recently put on a two-part series on geriatric anesthesia. Chronic Renal Dialysis has given special attention to the topic in all of its conferences. Internal Medicine residents currently are attending a series of seven geriatric conferences. Topics include

pharmacology, evaluation of confusion in the elderly, common complaints in the aging patient and health care resources in the community. All such programs are open and well attended by all sectors of the medical profession.

Students in the Aultman School of Registered Nursing are receiving significantly more geriatric training than they did even a few years ago, according to Carolyn Watkins, RN, director of the school. The addition was made in response to a growing need for such skills at Aultman where 65% of the RNs are graduates of the hospital school.

The Practical Nurse Program of the Canton City Schools from which many Aultman LPNs receive their training, this year incorporated into its curriculum a four-week course in a nursing home.

Joann Hawkins, RN, assistant vice-president of nursing, said she has noticed very little evidence of ageism in students coming out of both RN and LPN classes.

Absence of this bias and improved communication with patients is another effective though indirect way of expediting the healing process. One of the Social Service Department's vital functions is that of communication coordinator among patients, patient families, physicians, nurses, physical therapists, nutritionists and others involved in the care of the individual patient.

An important vehicle for such communication is the psycho-social assessment, a written evaluation by a social worker of patients referred to them by a physician. The social worker takes the assessment as far as is necessary to understand the practical psychological needs of the patient. A copy of the information is put with the patient's chart.

Seen by or discussed with physicians, it can shed light on diagnosis, treatment planning and effectiveness. Shared with a nurse it can improve patient relationship.

Finally, it prepares the social worker to discuss discharge plans with patients who need continued care outside of the hospital. Equipped with understanding, the social worker makes patient and family aware of the various health care resources available in the community, their services, whether or not they are covered by insurance and what can be expected, realistically, from each of them.

"The goal is for the person to be satisfied with their own life," explains Jane Hoyt-Oliver, a medical social worker whose graduate training is gerontology. "It can mean the difference between good and bad health. And arriving at the most beneficial choice frequently prevents patients from having to return to the hospital."

Maintaining the elderly person's ability to care for himself is another of Aultman's ways of keeping the census down. Examples of this include wellness programs such as a three-phase cardiac rehabilitation program initiated this year, and advancements in cataract surgery.

Finally, Aultman is reducing the number of geriatric inpatients by increasing the volume of outpatient surgery.

Removal of small tumors, ophthalmic and minor plastic surgery are among several procedures being done more frequently on a same-day basis at Aultman. The practice is less traumatic for patients, results in fewer complications and costs less. **OSMA**

Charity Elefterin is the assistant to the editor of publications at Aultman Hospital, Canton, Ohio

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Dealing with Dementia

By Alfred A. DeMaria, M.D.

Dementia is the loss of previously possessed mental functions due to diffuse organic dysfunction of the brain. The patient with dementia may lose his/her ability to think and function, sometimes even to communicate (in short, loses those qualities that make an individual a person), but the outstanding characteristic feature of dementia is a deficit of memory function. Dementia imposes an incredible psychologic burden on the patient in the initial stages of the disorder, and a terrific social, medical, and economic burden on the family, physicians and society in the latter stages of the disorder. As the population of elderly persons in the United States increases, the number with dementia also increases. An estimated 2.3% of the population over age 65 has dementia of such severity that institutional care is necessary;¹ many more persons have milder forms of dementia and remain at large in the community. Even more unfortunate are the younger patients with one of the so-called presenile dementias. By the year 2000, an estimated 1.43 million persons will suffer from dementia in the United States.¹ The magnitude of the problem is staggering. An estimated \$10 billion was spent on the care of people suffering from dementia in 1980.

Physicians confronted with a patient who potentially suffers from dementia have three important roles. First, the physician must determine whether the patient truly suffers from dementia, or from one of the many disorders which mimic dementia. For example, patients with a receptive (fluent or Wernicke's) aphasia may be mistaken as having dementia, when in fact the patient has a focal brain lesion which produces a severe speech defect. Similarly,

By the year 2000, an estimated 1.43 million persons will suffer from dementia in the U.S. The magnitude of the problem is staggering

Vincent, et al, recently observed that the Angular Gyrus Syndrome may closely mimic Alzheimer's disease.² One of the most common causes of "pseudodementia" is depression.

Secondly, if the patient truly suffers from dementia, physicians next must try to determine if a treatable cause for

the dementia exists (Table I). A patient whose dementia is not reversible is condemned to loss of personality and mental capacities for the rest of his/her life, requiring constant supervision, and a dismal prognosis. However, if proper treatment is instituted early enough in the course of a reversible dementia, the patient may be restored to a normal level of mental functioning.

Finally, if a treatable cause for the patient's dementia has been meticulously excluded, and presumably an irreversible form of dementia (Table II) exists, the physician must provide the best symptomatic and supportive therapy available. This approach must include the family, since it often bears the brunt of the disease's ramifications in the latter stages.

The work-up of a patient with dementia begins with a good history, which may be difficult if not impossible to obtain from the patient. The onset and progression of the disorder are important, as are its manifestations. Demented people may get lost in their own home or neighborhood and may have difficulty recognizing people they should know. Historical aspects suggesting underlying metabolic disorders, or risk factors for vascular disease, or

continued next page

exposure to toxins, or possible trauma should be sought. The absence of a history of trauma should not distract one from the possibility of a subdural hematoma, particularly in an elderly person. The family history is important to exclude an inherited form of dementia, such as Huntington's disease. Alzheimer's disease tends to have an insidious onset with a fairly steady and relentless progression, whereas multiinfarct dementia presents with episodes of worsening of mental function, separated by intervals of a relatively stable level of mentation (a so-called "staircase progression"). A past history of meningitis or intracranial bleeding may suggest a predisposition to normal pressure hydrocephalus; the classical clinical triad of normal pressure hydrocephalus consists of dementia, gait disturbance, and incontinence. At least some patients with normal pressure hydrocephalus improve after ventricular shunting procedure. A rule of thumb is that patients with dementia rarely complain of a problem with their memory, whereas patients with pseudodementia due to depression, complain at length about their loss of memory, although this is certainly not always the case. Patients with Creutzfeldt-Jakob disease often develop myoclonic jerks of the extremities at some point during the course of this disorder, which is potentially transmissible.

A detailed physical examination then should be performed to look for evidence of an underlying metabolic, toxic, infectious, or traumatic etiology. A detailed neurologic exam is obviously important to look for evidence of increased intracranial pressure or focal CNS dysfunction. The so-called "frontal release signs" are not particularly helpful in diagnosing dementia, since many normal elderly patients may develop many of these signs. A mental status exam sometimes is helpful in distinguishing functional from organic disease.

Psychologic testing is a very useful tool in the work-up of patients with dementia. This testing can help distinguish between pseudodementia and true dementia, and also quantitate the severity of dementia present. Occasionally, psychologic testing may even suggest the underlying cause, although rarely is it so specific. In questionable cases, repeating the psychologic test battery several months after the initial testing may show evidence of a progressing dementing disorder.

Routine blood work should be obtained in all cases of dementia and should include CBC with indices and differential, urinalysis, and chemical screening for glucose, renal function, hepatic function, and electrolytes. The

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present**

work-up should also include a chest x-ray and any other radiologic procedures as indicated to exclude an underlying malignancy or infectious process. In addition, a sedimentation rate, and any other tests indicated to exclude an underlying vasculitis, should be obtained. Vitamin B12 and folate levels should be determined and if the suspicion of a deficiency of the former vitamin is high enough, a Schilling's test should be performed. A calcium level should be obtained. Evaluation of thyroid function should be performed. If indicated, screening for certain drugs or other toxic compounds, especially heavy metals, should be performed. If Wilson's disease is suspected, ceruloplasmin

and copper studies should be ordered. Serologic studies for lues also are indicated. Serum viscosity should be checked as well.³

A CT scan of the brain, with contrast if possible, should be obtained in all patients with dementia to exclude an underlying vascular malformation, mass lesion (such as abscess or tumor) and subdural hematoma. It should be noted that the presence or absence of atrophy on the CT scan does not correlate with the presence or degree of dementia or lack thereof. Normal pressure hydrocephalus may be suspected from the appearance of the CT scan, in which case further tests, such as radionuclide cisternography and/or CSF infusion studies, may be indicated.

EEG is one of the most useful tests in the evaluation of the patient with dementia, although its limitations must be emphasized. The EEG may contain diffuse slowing of background rhythms, which is a very nonspecific abnormality and is consistent with a variety of metabolic, toxic, and degenerative processes, although it is very sensitive for detecting organic brain dysfunction. However, the EEG may be normal in the very early stages of a dementia, so that a normal EEG does not necessarily rule out an underlying organic cause of dementia. EEG also may provide evidence as to whether the etiology is a diffuse or focal process. Occasionally the EEG may even be fairly specific for the etiology of the dementia, such as in Creutzfeldt-Jakob disease. It also may uncover continuous subclinical seizure activity as the cause of the patient's mentation difficulty (so-called ictal stupor).

Finally, if no other etiology for dementia can be found, and no contraindications are present, lumbar puncture should be performed. The CSF should be examined for cell count and differential, protein and glucose levels, routine, fungal, and tuberculosis stains and cultures,

cryptococcal antigen, and VDRL.

Neurologic consultation should be sought when the diagnosis of dementia is uncertain or there is inability to exclude a treatable cause of dementia with reasonable certainty. One would want to be particularly aggressive with patients under 65 years of age.

If a treatable cause for the dementia is found, appropriate therapy should be instituted as soon as possible. Many of the disorders listed in Table I are not always completely reversible, particularly if detection and therapy are delayed. If no treatable cause for the dementia is found, the most likely etiology for the patient's dementia on a statistical basis is Alzheimer's disease. A definitive antimortem diagnosis of Alzheimer's disease

usually is impossible, since even brain biopsy cannot always definitively diagnose this entity. Alzheimer's disease is a degenerative disease of the

Alzheimer's disease tends to relentlessly and inexorably progress until the patient is in a completely debilitated state.

central nervous system of unknown cause; there is no longer any reason to suspect that this form of "organic brain syndrome" is due to decreased blood flow to the brain or "hardening

of the arteries," as previously believed. Previously, a distinction was made between presenile (beginning under age 65) and senile (beginning after age 65) dementia of the Alzheimer type, but most authorities now believe these entities to be the same disease, although recent evidence suggests patients with a younger age of onset have a more rapidly progressive course.⁴ Although the course of Alzheimer's disease can be quite variable, in general, the disease tends to relentlessly and inexorably progress until the patient is in a completely debilitated state and dies of inanition.

Although the physician may not find a treatable cause of dementia in a particular patient, he/she should not forsake caring for these patients and their families. Many of these patients

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Dealing with Dementia

continued

can be helped significantly by treating complications that may arise. In particular, many of these patients become depressed, and benefit from psychotherapy and antidepressants. The families require much support and should be informed as to the likely course that the disease will take, to the extent that is possible. The physician must help make arrangements for the prolonged care of the patient, which eventually may include institutionalization. Peter Rabins and Nancy Mace of the Johns Hopkins Hospital have written an excellent book entitled **The Thirty-Six Hour Day** (Johns Hopkins University Press) which reviews many of the problems these patients and their families experience, and ways to cope with these problems. This book is excellent reading for any physician or person who has to deal with persons suffering from dementia. In addition, the Alzheimer's Disease Foundation may provide helpful information as well.

National Alzheimer's Foundation
360 N. Michigan Ave.
Chicago, Illinois 60601 **OSMA**

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TABLE I. Treatable or Potentially Treatable Causes of Dementia

(Modified from Wells CE, ed. *Dementia* 2 E F.A. Davis, Philadelphia, 1977)

Metabolic	Myxedema Parathyroid dysfunction Wilson's disease Hepatic dysfunction Hypoglycemia Limbic encephalitis and other paraneoplastic syndromes Cushing's syndrome Hypopituitarism Renal dysfunction
Vascular	Vasculitis Multi-infarct dementia Arteriovenous malformation
Deficiencies	Vitamin B ₁₂ /folate deficiency Wernick-Korsakoff syndrome
Toxins	Heavy metals (especially lead) Organic compounds Drugs
Infections	Brain abscess Encephalitis Meningitis (including fungal) Neurosyphilis
Miscellaneous	Noraml pressure hydrocephalus Carbon monoxide/hypoxia Heat stroke Dementia pugilistica (punch-drunk syndrome) Brain tumors (particularly of the frontal lobes) Hyperviscosity Ictal stupor

TABLE II. Untreatable Causes of Dementia

(Modified from Wells CE, ed. *Dementia* 2E F.A. Davis, Philadelphia, 1977)

Multiple sclerosis
Muscular dystrophy (certain types)
Down's
Inborn errors of metabolism (certain types)
Creutzfeldt-Jakob disease (subacute spongyform encephalopathy)
Huntington's disease
Pick's disease
Alzheimer's disease
Other neurodegenerative disorders, eg, Parkinson's disease



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Peptic ulceration and GI bleeding, sometimes severe, have been reported. Rufen[®] should be given under close supervision to patients with a history of upper GI tract disease.

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CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen, caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin: Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia, (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS). **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photo-allergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

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A couple of times a year, the OSMA offers living proof that —

Retirement Is Not a Dirty Word

By Karen S. Edwards

Retirement. How far down the road is it for you? Ten years? Twenty? Or is it just around the corner? Sooner or later, you're going to meet it face-to-face. How ready will you be?

To help physicians ease into this final stage of their career, the Ohio State Medical Association (OSMA), in conjunction with the American Medical Association (AMA), has begun to offer "retirement seminars," which allow experts in social security, as well as tax and estate planning to give you all the information you're going to need to know before retiring — and to answer those questions you may have.

"A rewarding retirement takes planning," says Greg O'Brien of the AMA's Department of Practice Management. O'Brien was the opening speaker at a retirement seminar held this past March in Columbus.

Many retirements are not as successful as they could be, O'Brien points out, for a number of reasons.

"There are many common mistakes," he says. "It could be a

hasty decision about the location of the retirement or it could be a lack of planned activities. Suddenly, the physician — who can list his/her profession as having the greatest percentage of workaholics than any other professional group — finds he or she has an extra 250 days to fill. And often, it is just as difficult for the spouse."

The spouse, in fact, should be consulted regularly in any retirement plans the physician may be making, O'Brien stresses.

"They have their own ideas about retirement, and you may be surprised how often they differ from yours."

Failure to anticipate a necessary adjustment in roles and attitudes is often another problem source.

"You've built up friends and a certain prestige in your community. Then you move to a place where no one knows you as 'Dr. so-and-so'. In fact, they may not even know you as a doctor. And that can take some adjustment."

The lack of sound financial planning

was cited as yet another reason some retirements go astray.

"Your plans may not be specific enough, perhaps you didn't take today's inflation under consideration, or maybe you just started planning too late," O'Brien says.

Your first step in planning your retirement is to get your personal and financial affairs in order.

"Consult with advisors, and other retired physicians," O'Brien advises, "then set definite and realistic goals for yourself — in writing. Examine your present office procedure and systems and decide if you want to wind down your practice — or sell it."

Increased competition among physicians has suddenly made an established practice very appealing, especially to younger physicians who are just starting out. But O'Brien cautions seminar participants on the subject of patient records. "The AMA takes a very conservative stand on patient records," he says. "We suggest you keep them yourself for as long as possible."



Retired physician, Claude S. Perry, M.D.



Seminar participants take notes on what to keep in mind while planning a retirement.

They are, he points out, your liability protection. They can come in handy when children are seeking genetic information, and too, old records sometimes have been summoned by courts to prove whether or not certain benefits should be awarded to survivors, based on the medical information these records contain.

"This doesn't necessarily mean boxes in your basement," O'Brien answered the groans from some of the participants. "You could always have them stored commercially, or put on microfilm."

In closing, O'Brien offered two more pieces of advice.

"Don't let your license or malpractice insurance expire .. you may change your mind about total retirement."

"Don't let your license expire, and don't let your malpractice insurance expire," he says.

"There is always the possibility that you may change your mind sometime in the future and take advantage of some of the clinical opportunities that are available to retired physicians," he says. "But before you do, you may find yourself having to take your board exam all over again."

Claude S. Perry, M.D., Columbus, is one physician who appears to have made the most out of his retirement. Accompanied by his wife Jo, Dr. Perry came to discuss the "Personal Side of Retirement" with seminar participants. The 84-year-old physician (who looks and acts 20 years younger) retired from his ophthalmology practice in 1976 — after 50 years in medicine.

"Continue to plan on changes occurring," he advises, "because they do." Then he dispensed some common sense, homespun advice that may be overlooked by those just

heading into retirement.

"If you're going to travel, do it early in your retirement, because later on, you won't feel like it. And if you are looking into buying another home — or building one — make it a one-floor plan," he advises.

Following are some pointers from those seminar speakers who addressed other retirement-oriented topics.

Perhaps, from them, you can pick up some pointers which may help you to enjoy your own retirement.

Social Security. Speaker: Linda Kovalsky

Each month, approximately 4 million checks are sent to Ohio retirees and their dependents. If you are approaching retirement, here are some facts you'll want to keep in mind about social security, and its benefit program:

- To be eligible for social security's retirement benefits you must:

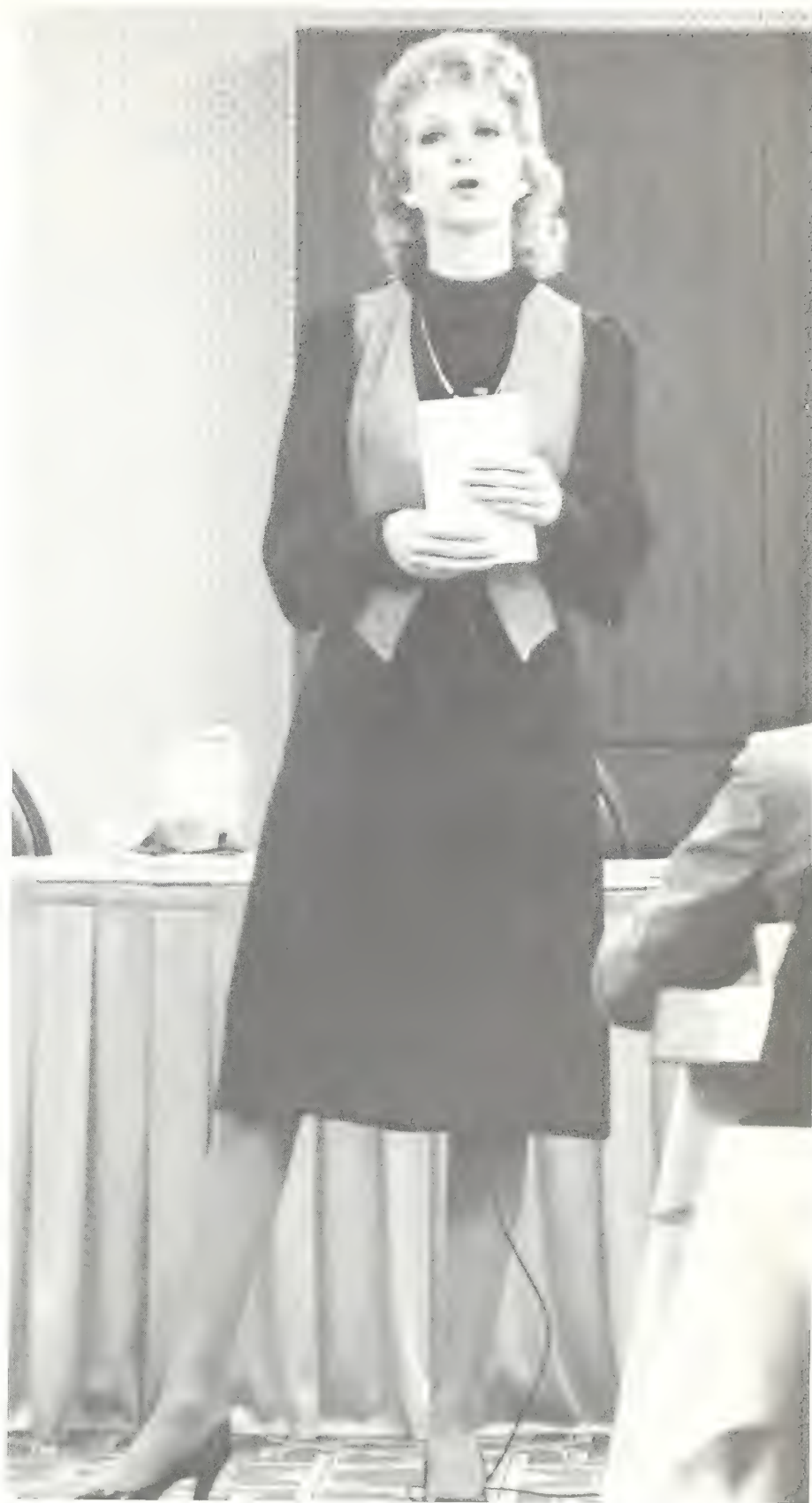
1. Be at least 62 years old.
2. Be fully insured.
3. Have sufficient "quarters of coverage." (You must earn at least \$370 a year to obtain one quarter of coverage. A total of \$1,480 equals four quarters of coverage. *No one needs more than 40 quarters of coverage to be eligible for social security benefits.*)

- To find out the number of years social security will be income-averaging your salary to determine your benefit — take the year of your birth (last two digits), and add 6. (Remember though, that this will not be more than 35 years.)

- If you are receiving social security benefits and are still earning an income, the limit you may earn in 1983 without being penalized is: age 65-70, \$6,600/year; under 65, \$4,920/year. If you exceed those limits, social security will withhold \$1 out of every \$2 you earn from your benefit check. If you are 70 years or older, you may earn any amount of money and not be penalized by social security.

- If you plan on taking an early retirement, it will mean reduced benefits. How much will you receive? If you take your retirement at 62 — 80% of your benefit; at 63 — 86% of

continued next page



Seminar speaker Linda Kovalsky provided participants with information on social security.

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Retirement Is Not A Dirty Word

continued

your benefit; at 64 — 93% of your benefit; at 65 — 100% of your benefit.

- If you plan on taking your retirement later than age 65, you will receive delayed retirement credits. If you were born in 1916 or before, you will receive 1% credit per year (on top of your primary insurance) based on social security's old way of computing benefits. If you were born in 1922 or later, you will receive 3% credit, based on the new indexed method calculation. If you were born between 1917-1921, the rate will be calculated both ways (old and new), you will be given the higher benefit. The delayed retirement credit is 3% for anyone born 1917 or later.

- The maximum retirement benefit is \$709 a month (this figure changes annually), for a worker aged 65 with maximum earnings.

If you take your retirement at age 62, you will receive 80% of your benefit. If you delay retirement till after you're 65, you will get delayed retirement credits.

- A dependent spouse must be 62 to file. He/she will receive 37½% of the worker's full rate at that age, and 50% if he/she waits until 65. If the spouse has worked and has full quarters of coverage, social security will compute the spouse's benefits both as a worker and as a dependent.

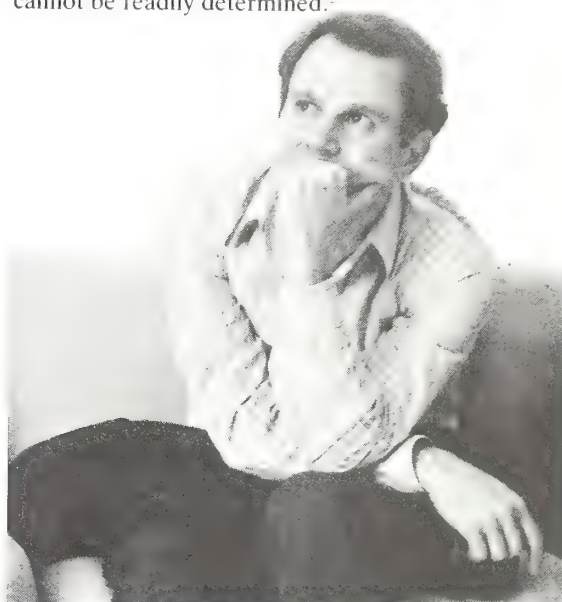
- The spouse can be paid his/her benefits as a worker *plus* the difference between those benefits, and what he/she is entitled to as a dependent under the partner's benefits. For example, he receives \$600. She receives \$200 on her own benefits, but is entitled to \$300 as a dependent under his benefits. Social security will pay her an additional \$100.

- You may file up to three months before you begin your retirement. To file, bring your birth certificate (or

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5,000,000 hospital patients with infections.¹

Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.²



Berocca Plus. A balanced formula for prophylactic or therapeutic nutritional supplementation. Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

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THE MULTIVITAMIN/MINERAL FORMULATION

1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME: Philadelphia, Lea & Febiger, 1980, p. 1114

Please see summary of product information on reverse page.

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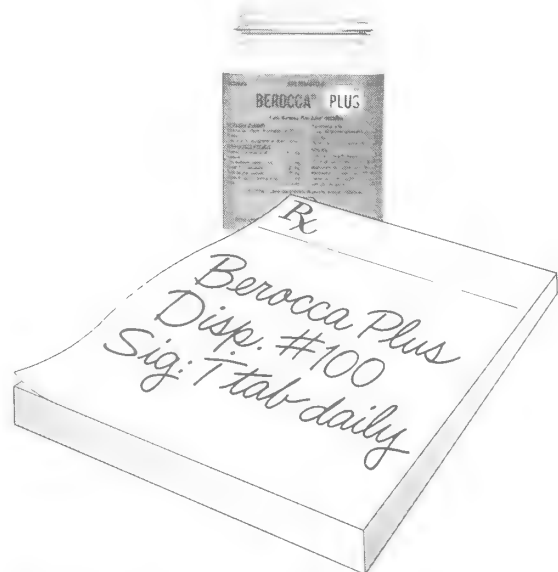
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Before prescribing, please consult complete product information, a summary of which follows:

Each Berocca[®] Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *d,l*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B₁ (as thiamine mononitrate), 20 mg vitamin B₂ (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B₆ (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B₁₂ (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage, one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets — bottles of 100.



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Retirement Is Not A Dirty Word

continued

other proof of age) and your W-2 forms from the last two years with you to your social security office.

- Medicare's Part A which provides hospital/nursing home coverage is free to anyone entitled to a social security check. Part B, which provides medical coverage, is \$12.20 a month, which is automatically deducted from your social security check when you reach 65, unless you notify the social security office to do otherwise. If you are 65 and not receiving a monthly check, you will be billed quarterly for your premiums.

- Part A provides for 90 days hospitalization and 100 days in a skilled nursing facility per benefit period, with a \$304 deductible. Sixty reserve days also are held for you, but once you use a reserve day, you cannot get it back. Part B carries a \$75 a year deductible.

- If you are divorced, and still single, and had been married at least ten years to your ex-spouse, you may still claim on his record as a dependent. (It will have no affect on the benefit of any other dependents on that record.

Tax and Estate Planning.

Speakers: Jeffrey Luedke, Sam Sorkin, Richard Denney, Coopers and Lybrand Accounting Firm, Columbus, Ohio.

- There are two basic principles in planning your financial future: 1. Make sure that you will have enough assets to maintain your standard of living.

2. Take a look at what you have now, and what you need in the future, and act accordingly.

- Consider the economic risks that face you: death, disability, medical expenses, retirement and loss of capital (due to liability/damage). To manage these risks:

1. Establish your objective.
2. Invest your assets to cover these risks.

3. Draw conclusions.

- With regard to the "spendable income technique," the theory is that

you won't need as much income when you retire. For example, if you presently need \$25,100 to maintain your current level of need, then you will need \$12,100 to maintain that level in retirement.

- Establish your assets: Do you have a benefit plan package (corporate retirement or a medical plan)? If you do, make sure you understand it. Ask questions if you don't. No one is looking out for you but you. Know your benefits under social security. And determine your personal assets — house, car, insurance policies, IRAs or Keogh plans, annuities, etc.

- Draw conclusions — is there a severe "short fall" between your assets and what you will need to live comfortably in retirement? If so, your objectives may be too aggressive, you may want to adjust them. Or you may want to continue working. Don't forget that your social security benefits will be cut if you do continue working, however.

- Insurance can be a large expense. Reduce or eliminate excess coverage. The basic types are as follows:

- Term. Low costs, premiums increase with age. No cash value. Pure death benefit. Guaranteed renewable.

- Permanent (whole life). Higher costs, death benefit with cash value (less pure death benefit/more cash value). Can borrow against cash value at low rate, and invest at a higher rate.

- Universal life. Highly flexible.

- Second death. Involves a couple, pays benefit only on the second death.

- Annuities are the opposite of life insurance. You are betting that you will outlive the mortality table and collect. They can be used as a tax shelter, however.

- Your taxable income is your income, minus exclusions, deductions, itemized deductions and exemptions. Take advantage of tax shelter plans to reduce this income further.

- One way to reduce taxable income is by way of intra-family income shifting. A short-term trust can be established in which you give some of your income to a child or someone in a lower tax bracket, so that it will be taxed at a smaller rate. However, if the amounts shifted are very large, you may be charged with a gift tax, and a

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short-term trust will tie up your assets for ten years.

- On vacation homes, you can earn up to two weeks rental income tax-free, and you can take tax deductions on it if, as the owner, you stay in it yourself only 10% of the time you have it for rent (or no more than 14 days if you are not renting it).

- Do make out a will. You have the legal right to one, and through it, you can appoint a guardian for a minor child, name an executor, make provisions in case you and your spouse are involved in a simultaneous death and can minimize taxes filed on your estate.

- There are three types of wills:

- 1.) The Ma/Pa will — no dependents, everything is left to the survivor.

- 2.) Old tax will — half of property is left to spouse, half is left to a by-pass trust (held by a third party).

- 3.) New tax will — the majority of the estate is put in a by-pass trust, the balance goes to the spouse.

- Jointly owned property is usually a mistake. While it may have the advantage of saving probate costs, its disadvantages are that there may be a taxable transfer at time of death, it saves nothing in taxes, and may even result in an overpayment of taxes, precluding good estate/tax planning.

- In summary, know your assets, decide where you want your assets to go, apply basic principles of tax planning and keep your wills up to date (revise at least every five years).

Anyone interested in attending a future retirement seminar may obtain further information by contacting the Department of Continuing Medical Education, the Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215. OSMA

Karen S. Edwards is Executive Editor, the Ohio State Medical Journal

THE EXPERTS AGREE...

ZYLOPRIM[®] (allopurinol) IS SIMPLE, EFFECTIVE GOUT THERAPY

Unlike uricosuric agents, Zyloprim[®] (allopurinol) is clearly the choice for:

OVERPRODUCERS/ UNDEREXCRETORS

"One recent suggestion is that overproducers of uric acid are more 'appropriately' treated with allopurinol and underexcretors with uricosuric drugs. Such an argument is superficially attractive but may be specious: most patients with gout... may nevertheless be managed perfectly well with allopurinol."¹

—G. Boss, MD et al

TOPHI, CALCULI, RENAL DISEASE

"... (1) patients with extensive tophaceous disease...; (2) patients with a history of renal calculi... since a uricosuric drug may exacerbate renal stone disease; and (3) patients with significant renal disease... who are unlikely to respond to a uricosuric drug."²

—Edward W. Holmes, Jr, MD

For information on adverse reactions, warnings, etc., please see brief summary of prescribing information below.

ZYLOPRIM[®] (allopurinol)
100 and 300 mg Scored Tablets

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim[®] (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been

observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease. Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Occasional cases of hypersensitivity have been reported in patients with renal compromise receiving thiazides and Zyloprim concurrently. For this reason, in this clinical setting, such combination should be administered with caution.

In patients receiving Purinethol[®] (mercaptopurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age:

Zyloprim should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully

"The most important therapeutic measure is the administration of a drug which will block urate synthesis. The agent available at present is allopurinol (Zyloprim...) which is very effective and of low toxicity."³

—Alfred Jay Bollet, MD

"... allopurinol treatment appears to retard the progression of renal dysfunction."⁴

—T. Gibson, MD et al

LOW INCIDENCE OF TOXICITY

"Clinical experience with allopurinol suggests that most patients tolerate this drug well—a finding strongly supported by our data. Undesired or unintended effects of therapy were reported in only 1.8% of 1835 consecutive recipients."⁵

—G. T. McInnes, MD

1. Boss G, et al, quoted by Scott JT: Long-term management of gout and hyperuricemia. *Brit Med J* 281:1164, 1980.

2. Holmes EW Jr: A rational approach to gout. *Drug Therapy* 11:117-124, 1981.

3. Bollet AJ: Prevention and treatment of urate nephropathy and uric acid stones. *Resident & Staff Physician* 28:57-64s, 1982.

4. Gibson T, Highton J, Potter C, et al: Renal impairment and gout. *Ann Rheum Dis* 39:417-423, 1980.

5. McInnes GT, Lawson DH, Jick H: Acute adverse reactions attributed to allopurinol in hospitalised patients. *Ann Rheum Dis* 40:245-249, 1981.

observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects. Mild reticulocytosis has appeared in some patients.

Periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported. The incidence of skin rash may be increased in the presence of renal disorders.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Hepatic: Rare cases of granulomatous hepatitis and hepatic necrosis have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.



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Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim has been neither implicated nor excluded as a cause of these reactions.

Renal: Rare cases of renal failure have been reported in hypertensive patients who received thiazides and Zyloprim concurrently. Some patients had evidence of hypersensitivity to allopurinol.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yu for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)

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Geriatrics. Our Profession's Newest Responsibility

continued

convenience of the physician. Physicians are still in short supply and their time is very valuable. But can society continue to afford this kind of care for its elderly? Two hundred elderly living in a retirement center may have today 50 or 100 different physicians caring for them, physicians with offices perhaps miles apart from the retirement center. Can society afford the increasing cost of transporting these patients to their physicians as their impairments and immobility increase with age? What is said about transportation can be said about finance. The complicated multiple billings of today's practices are confusing and often unmanageable by the elderly. Many health care skills *can* be performed adequately by nurses or assistants, or allied professionals, sometimes economically and more efficiently than by physicians. But, if nurses and other health care professionals practice "wellness" independently, with separate offices and separate charges, then the elderly will have to meet additional professional costs, and transportation requirements. Can the elderly in the future afford this kind of distinctly different, almost territorial approach to health care, or is there a need for a highly integrated and directed interdisciplinary team approach, which delivers health care at a location that is convenient for the patient?

Geriatrics is becoming identified as primary medical health care service, with expanded responsibility. It requires physicians with special knowledge and skills, who will work closely with a team of health workers including nurses, social workers and perhaps physical therapists and occupational therapists. Perhaps what is needed is this closely coordinated and integrated team reaching out, identifying the special medical and psycho-social health needs of the elderly — then adjusting the system and methods of delivery to meet these special needs. Perhaps a new method of health care delivery eventually will have to be incorporated into our profession.

Certainly our profession has an obligation to look at today's

population and today's health care system, and to do what we can to improve it. But we need to keep the future in mind. Every indication shows that our future will be crowded with a gigantic elderly population with special health care needs. . . and it is going to be up to us to meet them.

Our system of health care delivery is going to have to be designed to meet these growing, special needs. Ideally, it will be a service designed for the convenience of the elderly — not necessarily for the convenience of the providers. And ideally, it will be a service which is provided by a team of integrated, coordinated health care professionals. Ultimately, it's going to be a service which will provide a great deal of personal satisfaction and rewards — for patient and provider alike.

The old and the very old deserve our best care. It is our profession's

new responsibility to make ourselves aware of the very special problems of geriatrics, and to do what we can to meet these problems. **OSMA**

Roy L. Donnerberg, M.D. is co-director of the Office of Geriatrics/Gerontology, College of Medicine, Ohio State University, Columbus, where he also serves as an Associate Professor of Medicine. George Bonnell, M.D., (Aging. The Disease Research Almost Forgot.) Columbus is Chairman of the Education Committee, American Federation for Aging Research, Ohio affiliate. The manuscript was prepared with the assistance of Karen S. Edwards, Executive Editor, Ohio State Medical Journal.

Children of parents who smoke are susceptible to chronic middle ear disease

Children whose parents smoke are more likely to develop chronic middle ear disease than those who live in smoke-free homes, says a group of Seattle physicians in a recent issue of the *Journal of the American Medical Association*.

Headed by Michael J. Kraemer, M.D., from the Division of Allergy at Children's Orthopedic Hospital and Medical Center, Seattle, the researchers compared a group of children hospitalized for tympanostomy-tube insertions due to persistent middle-ear effusions (fluid build-up in the ear) with a control group of children hospitalized for other reasons. The groups were matched for age, sex, racial background, family size, household exposure to cigarette smoke, and frequency of catarrh (nasal congestion) and middle ear infections (suppurative otitis media).

The authors found three factors involved more often in children with

persistent middle-ear effusions (PMEE): catarrh, exposure to household cigarette smoke and atopy (a predisposition to certain allergies).

The authors noted that nearly all the hospitalized children with PMEE had had one or more previous episodes of otitis media while only 59% of the control group had had similar episodes. Frequent ear infections sharply increase the risk for persistent effusions, according to the authors, and the risk is greatest when all three factors are present.

"Exposure to two or more household cigarette smokers increased the risk for PMEE nearly threefold. With household exposure to smoke from more than three packs of cigarettes per day, the risk increased fourfold," says Dr. Kramer. "Children with all three factors — nasal congestion, cigarette smoke exposure and atopy — were more than six times as likely to manifest PMEE."

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Plus** TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC, National Academy of Sciences, 1980, p. 13.

Please see summary of product information on reverse page.

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Optimize nutritional support with

Rx ONLY **Berocca[®] Plus[®]** TABLETS
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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General.* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient.* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

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CONTINUING EDUCATION PROGRAMS

NEPHROLOGY UPDATE - 1983:

May 11-13; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 22 credit hours; fee: \$195, \$125 for residents and allied health professionals; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll Free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

RECENT DEVELOPMENTS IN THE MANAGEMENT OF DIABETES MELLITUS:

May 18; Lutheran Medical Center School of Nursing Auditorium, 2609 Franklin Blvd., Cleveland; 5 credit hours; no fee; contact: Billie Seidenwand, 2609 Franklin Blvd., Cleveland 44113, phone: 216/363-2146.

ADULT CONGENITAL HEART DISEASE:

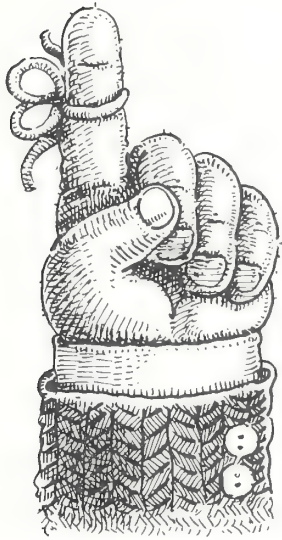
May 18-19; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 13 credit hours; fee: \$160, \$110 for residents and allied health professionals; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll Free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

NEURO-OPHTHALMOLOGY FOR THE PRACTITIONER:

May 20-21; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$185, \$120 for residents; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll Free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

continued on page 395

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For more information on Harmarville, its head injury program and admission procedures, call Dr. Amayo, 781-5700.



Harmarville Rehabilitation Center, P.O. Box 11460, Guys Run Road, Pittsburgh, PA 15238

Obituaries

BRACK BOWMAN, M.D.,
Youngstown; University of Cincinnati College of Medicine, 1929; age 83; died March 12, 1983; member OSMA and AMA.

PAUL H. CHARLTON, M.D.,
Evanston, Illinois; Ohio State University College of Medicine, 1921; age 88; died March 23, 1983; member OSMA and AMA.

WALTER W.F. DYCKES, M.D.,
Willowick; Case Western Reserve University School of Medicine, 1929; age 80; died January 15, 1983; member OSMA and AMA.

WYNDHAM FRYE, M.D.,
Cambridge; University of Tennessee College of Medicine, Memphis, 1976; age 40; died February 5, 1983; member OSMA and AMA.

JOHN F. HAAS, M.D., Cleveland;
Ohio State University College of Medicine, 1926; age 83; died January 31, 1983; member OSMA.

ALBERT L. JONES, M.D.,
Cleveland; Case Western Reserve University School of Medicine, 1916; age 97; died February 2, 1983; member OSMA and AMA.

RICHARD C. JONES, M.D., Logan;
University of Kansas School of Medicine, 1937; age 71; died February 5, 1983; member OSMA and AMA.

JEAN ADAM NOCK, M.D.,
Monroe; University of Cincinnati College of Medicine, 1933; age 76; died February 3, 1983; member OSMA and AMA.

JOHN G. REPASKY, M.D., Akron;
Ohio State University College of Medicine, 1928; age 83; died January 30, 1983.

DANIEL PLATT, M.D., Cleveland;
Ohio State University College of Medicine, 1946; age 62; died January 23, 1983.

NORMAN SCHROEDER, M.D.,
Kenton; University of Michigan Medical School, Ann Arbor, 1924; age 82; died March 12, 1983; member OSMA and AMA.

FREDERICK G. SMITH, M.D.,
Marion; Northwestern University Medical School, Chicago, 1933; age 71; died January 7, 1983; member OSMA and AMA.

CHARLES STEVERS, M.D., Biloxi, Mississippi; Ohio State University College of Medicine, 1943; age 65; died December 8, 1982.

BRUCE STEWART, M.D.,
Cleveland; University of Michigan Medical School, 1954; age 54; died February 16, 1983; member OSMA and AMA.

JAMES A. TALBOT, M.D., Geneva;
Laval University Faculty Medical, Montreal, Quebec, 1933; age 76; died February 14, 1983; member OSMA and AMA.

CARL A. WILZBACH, M.D.,
Cincinnati; University of Cincinnati College of Medicine, 1922; age 93; died February 18, 1983; member OSMA and AMA.

MICHAEL ZEIGER, M.D.,
Cleveland; Case Western Reserve University School of Medicine, 1929; age 78; died February 1, 1983; member OSMA.



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CLINICAL NOTES

Edited by Karen S. Edwards

Clonidine hydrochloride poisoning in children

Clonidine hydrochloride poisoning in children has become more frequent as the antihypertensive drug gains increasing popularity in the United States. The authors state that it is important that physicians, responsible for the care of children, be familiar with the symptoms of clonidine poisoning, and with the treatment of clonidine overdosage.

The most frequent and significant toxic effects are depression of consciousness, bradycardia, hypotension and respiratory depression. Ventilatory support must be available if apnea occurs. Bradycardia can be treated with atropine sulfate, epinephrine chloride, dopamine hydrochloride or tolazoline hydrochloride. Hypotension is treated with intravenous fluids and dopamine, reserving tolazoline for refractory cases. Hypothermia is common but is of minor clinical significance. Paradoxical hypertension should be treated with tolazoline. Clonidine may not be detected in body fluids by routine toxicology screening procedures, so poisoning should be suspected on clinical grounds.

**American Journal of Diseases of
Children**

*Volume 137, No. 2, February, 1983
pages 171-174*

Appropriate hypertension therapy

The author of this article states that "early and aggressive" drug therapy for mild hypertension, now widely prescribed in the United States, may be inappropriate for many of the 30 million patients with this condition. Although all of these patients are at greater risks of premature cardiovascular disease, the risks are manifested neither quickly nor uniformly. Drug therapy has not proved beneficial for patients with a diastolic (D) BP reading below 100 mm Hg, particularly those patients who are otherwise at low risk. Those antihypertensive drugs that are available now carry risks along with their benefits. Therefore, persons with mild hypertension who are at low risk should be encouraged to use nondrug therapies for at least six to 12 months. If their DBP remains below 100 mm Hg they may be better off than if they were given drugs. The drug used in initial therapy has usually been a diuretic. For many patients, however, an adrenergic inhibitor may be a more appropriate choice.

—**Archives of Internal Medicine**
*Volume 143, No. 2, February, 1983
pgs. 255-259*

Methaqualone abuse

Methaqualone first was marketed in the United States in 1965 as a safe, nonaddicting sedative and hypnotic drug. Within a few years, its abuse potential became evident, and methaqualone was given Schedule II status. Presumably, this resulted in a relatively restricted supply of the drug and a decrease in methaqualone abuse. Recently, however, reports indicate a resurgence of abuse, although with a markedly different pattern. The pattern of fatal methaqualone abuse has changed from an overdose phenomenon in the early 1970s to one of traumatic death. Victims frequently have exhibited poor judgment, impulsive behavior and

somnolence while attempting to function in their environment.

The authors conclude that the socioeconomic impact of recreational methaqualone abuse should be curtailed by appropriate governmental action and restraint in the prescribing of methaqualone.

**Journal of the American Medical
Association**

*Volume 249, Number 5, February 4, 1983
pgs. 261-266*

Alexia without neurologic deficit

A transient episode of alexia in the absence of accompanying neurologic deficit is exceedingly rare. In 1943, one such case appeared as a manifestation of decompression sickness. The authors, however, recently observed a patient who experienced an isolated transient alexia that appears to have been a migrainous accompaniment.

The case in question emphasizes, according to the authors, the diagnostic dilemma of the stroke-age patient who has a history of transient ischemic attack but normal results of angiographic and medical workup. The importance of late-life migraine accompaniments in the origin of such unexplained ischemic phenomena is emphasized by the authors, noting that within two months of the episode of alexia, their patient experienced, for the first time, visual scintillations, characteristic of classic migraine.

Other sources have recognized that the pattern and nature of migrainous attacks often change during midlife. The authors speculate that the lack of an accompanying neurologic deficit suggests a highly localized area of ischemia was responsible. A history of migraine argues strongly for migraine-induced vasospasm as the mechanism responsible for the alexia in this patient, particularly in view of the negative results obtained from the medical and angiographic workup.

Archives of Neurology
*Volume 40, No. 2, February, 1983
pgs. 115-116*



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CME Courses for June

NUTRITION IN CRITICALLY ILL PATIENTS: June 2-3; Stouffer's Cincinnati Towers; sponsor: University of Cincinnati Medical Center; 12 credit hours; fee: \$250, \$125 for residents; contact: Janet Eckart, University of Cincinnati Medical Center, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5851.

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PR Practice

Communication with your
staff, your patients, your
public

Mark Twain classified them as "lies," damned lies and statistics," but at a recent meeting one statistic cropped up that couldn't be ignored: half of the people in the history of the world who lived to reach age 65 are alive today.

Since the elderly seek medical care more often than younger people, you probably already know this. Through the years you may have noticed a steady increase in the number of elderly patients in your practice.

The medical and social implications of this phenomenon will be significant. While the elderly aren't asking for preferential treatment, they do have some special needs. By becoming aware of those needs, you can make your office more responsive to your patients.

If you are like many Ohio physicians, your office already is starting to feel the pinch of increased competition, both from other physicians and from new innovations in the health care delivery system — such as HMOs and free-standing emergency centers. Since referral from family and friends is still the method by which most people choose a new physician, the best way to build your practice is to keep the patients you have happy. This is particularly true of elderly patients since they can be an excellent source of referral.

The most effective and easiest way to keep your elderly patients happy is to make them feel they have your respect. For example, take the issue of names. The OSMA occasionally receives calls from irate people who complain that their physician or, worse yet, a member of their physician's staff — young enough to be a grandchild — called them by their first name. Many elderly people find this distressing because it is interpreted as a sign of

The Elderly in Your Practice

By Carol Wright Mullinax

disrespect. To add insult to injury, they must address the physician as "doctor."

Now may be the time to rethink your habits in addressing all of your patients. Call new patients by their title and surname until asked to do otherwise. This is especially important for your staff since they don't have the status that you do by being a physician. It is a simple courtesy but one that can go a long way in making all of your patients — especially the elderly — feel they have your respect.

Another courtesy that will make the elderly feel a little more at home in your office is to make your office a little more like home. Bear in mind that older people may find long waits discomforting. If you must keep patients waiting, offer them coffee or tea and make certain they have access to a bathroom. Instruct your staff to allow those elderly patients who need it, a little extra time to get back to the examining room. You may want to assign a staff person to accompany them and assist them — if necessary — in getting up on the examining table.

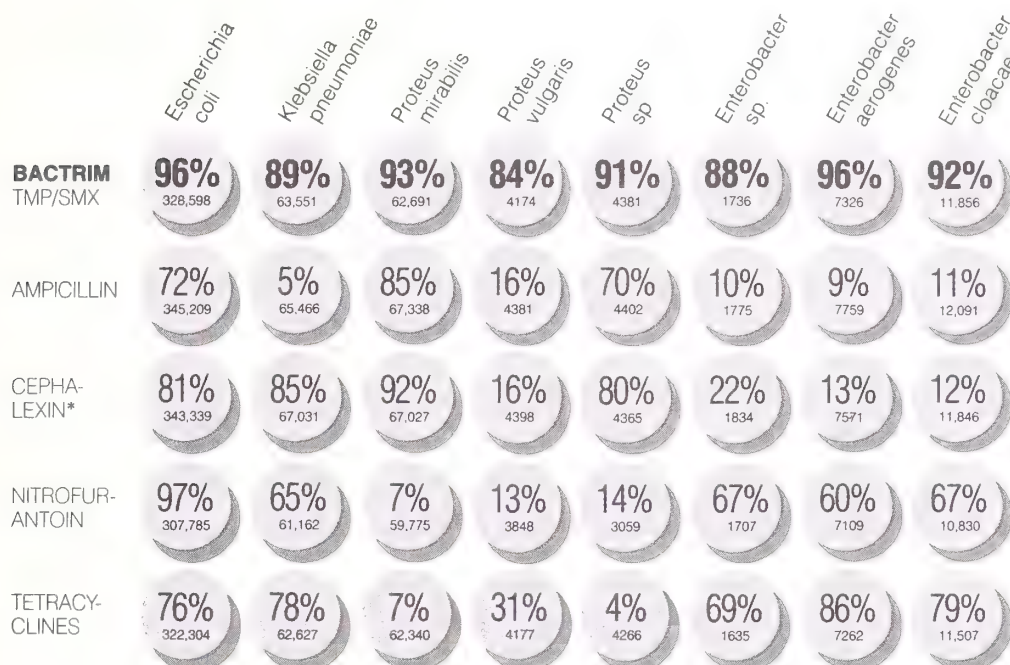
Remember too, that consideration extends beyond the actual examination. Explain their medications to them. Make sure they understand why and how to take them. Medical insurance forms are confusing for everyone. Have your staff offer to assist elderly patients in completing Medicare and other insurance forms and make certain your staff is well-acquainted with the Medicare program—particularly the areas of coverage and level of reimbursement—so all of your patients' questions can be answered. Keep in mind that financial considerations often become more critical after retirement and it is

especially important to discuss the cost of treatment with elderly patients.

One of the biggest problems facing physicians who see a significant number of elderly patients is the amount of time a routine office visit can take. You may have noticed in your own practice that the elderly tend to linger over appointments just to chat. It is true that, by taking those few extra minutes, you can brighten the day for lonely elderly patients, but it is a short-term solution for a chronic problem. The most satisfying solution for elderly patients who show signs of loneliness is to help put them in touch with other people. You can do this by having your staff gather information on all the programs in your community which are designed for the elderly. For example, many communities sponsor some type of meal programs for the elderly. Getting together with other people once a day to share a meal is an excellent idea for elderly people who live alone and don't fix nutritious meals for themselves. Many programs also deliver meals to the homes of elderly who aren't able to get out. In addition to meal services, some cities also offer free or reduced cost home health, housekeeping and transportation services for qualifying elderly. Find out what your community offers and make that information available to your patients. It not only will cut down on the amount of time you spend patting hands, it will help improve the overall mental and physical health of your elderly patients. **OSMA**

The right choice against all these uropathogens

Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials



*Analogous to cephalothin, the primary antibiotic disc used in testing.

Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series 1981-82.

Numbers under percentages refer to the projected number of isolates tested.

Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency. Maintain adequate fluid intake and perform frequent CBCs and urinalyses during therapy. Initial episodes of uncomplicated urinary infections should be treated with a single-agent antibacterial.

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References: 1. Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 2. Spicehandler J et al: *Rev Infect Dis* 4:562-565, Mar-Apr 1982. 3. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 4. Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 5. Cooper J, Brummitt W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. 6. Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. 7. Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. 8. Irvani A et al: *Antimicrob Agents Chemother* 19:598-604, Apr 1981. 9. Rous SN: *J Urol* 125:228-229, Feb 1981. 10. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series 1976-82. 11. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL

PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsilopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN.

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

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Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Packs of 20. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Packs of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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Letters ...to the editor

Article well-timed

To the Editor:

Just a little note about the March issue of the *Ohio State Medical Journal*. I was particularly impressed and intrigued by the article on Crohn's disease by Drs. Coccia, Ferrara, Martin and Zollinger of Ohio State University Hospitals. Within the past year, I had the opportunity to operate on one of these patients and, although I was familiar with the disease by name, knew nothing of its etiology and progression at the time. In view of this, I was extremely interested by the article, impressed with it and found it to be extremely knowledgeable and well presented. Please convey my compliments and thanks to the authors.

Very sincerely yours,
/s/L. David Hall, M.D.
OB-GYN Clinic Inc.
Columbus, Ohio

Changes observed

To the Editor:

I read the "Abuse in UCR" by Dr. Leonard B. Greentree and I agree 100 percent.

I graduated in 1937 and have seen the changes Dr. Greentree has called to our attention.

I hope there will be a change in the direction Dr. Greentree suggests. Otherwise, the government will take over our profession.

Sincerely,
/s/Bernard R. Bonnot, M.D.
Canton, Ohio

Do you have a grievance to air, an opinion you'd like to share? Please send your "Letters to the Editor" and "Second Opinion" articles to: Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.



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VARIETY AND CHALLENGE = NAVY MEDICINE



Thoughts on the Nuclear Age

By Roy H. Thompson, M.D.

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

To deny the unlimited and wonderful advances in the peaceful use of nuclear energy would be a giant step backward for mankind. Underdeveloped nations now can be brought more rapidly into the modern world, while developed nations continue to reap more bountiful blessings as our knowledge and experience grow.

However, like most scientific advances, nuclear power is a two-edged sword. It can help mankind and it can hurt. Both uses now are being relentlessly researched. Due to our superficial intercommunication between technology and sociology, we listen to the call of the latter as more easily grasped, forgetting that basically all matter, whether living or nonliving, consists of an infinitesimal central positive nucleus surrounded by orbiting electrons, tiny bundles of energy which, themselves, are

magnetism, a principle now used in medical imaging by the nuclear magnetic resonance camera (NMR).²

A known primary potential cause of cancer is radiation. Apologizing for oversimplification, one may say that when a living cell undergoes mitosis (cell division), its anaphase is most at risk and may be hit by particles of radiation. One or more chromosomes may be injured which would result in cell death, cancer, or a usually serious genetic mutation.³⁻⁵ This carefully controlled phenomenon is used in radiation therapy to destroy an existing cancerous growth but in nuclear warfare large areas of normal body cells are radiated and many are injured in varying degrees by the same process.⁴ The dose depends upon the distance from Ground Zero, how well protected the body is, and whether the dose is immediate or prolonged, as it is during fallout.⁶

Like most scientific advances, nuclear power is a two-edged sword. It can help mankind and it can hurt. Both uses now are being relentlessly researched.

radioactive or can be made so, and thereby detectable by an electroscope, our seeing eye.¹

Matter constantly is being bombarded by unstable cosmic, terrestrial or inherent body particles of radiation. These inherent energy bundles also obey the laws of

Matter can neither be created nor destroyed but it can be dramatically altered. Nuclear research reached a tremendous milestone 40 years ago in a fiercely fought World War II race that fortunately for the "Allies" was won by the United States.

continued on page 405



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Among the fission products of nuclear blasts are innumerable harmful radioactive isotopes with varying half-lives. Two of them are Strontium 90, a bone seeker and Cesium 137, retained by soft tissue.

Field tests which followed showed an average immediate fatality potential rate of 35% due to blast injuries, 50% thermal and 15% radiation.⁶

In a nuclear war uncontaminated food and water and medical care would be largely nonexistent. Depending upon the severity of the encounter, up to hundreds of millions of victims over land and water, including animals, could be killed, blinded or maimed within a brief time period.⁷ In the target areas, animals and fish could become inedible.⁸ Epidemics would be rampant due in large part to the lowered resistance of the host by irradiation. Electronics, vital to modern warfare, would be temporarily useless due to electromagnetic pulses and radiation, and the ozone layer protecting us from the full force of cosmic rays would be disrupted indefinitely.⁷

The long-term effects remain to haunt those who survive. The use of millions of square miles of land around the target areas would be denied for years.⁹ There would be a marked increase in the rate of cancer, and serious-to-fatal genetic mutations would occur for decades, perhaps to infinity.¹⁰ Cancer susceptibility is additive and pre-existing carcinogens such as cigarette smoke increase the risk.¹¹

Civil defense measures reduce casualties and improve the immediate survival rate significantly, thereby retaining government functions by underground administration buildings, hospitals and factories, all proportional to their degree of elaborateness.¹² Journalist James Joseph, in an article which appeared in the *Cleveland Plain Dealer* on Sunday, November 7, 1982, states that Russia, Switzerland and

Norway are presently the leaders in this field accommodating major portions of their populations. With very little effort and cost, we too could achieve some measure of protection by receiving critical vaccinations and inoculations, and by obtaining first aid, CPR, radiation monitoring, shelter training and similar courses of instruction.

All knowledge is available to all people and cannot indefinitely remain secret. Recent discoveries of new uranium ore deposits have added to its availability which now exists on every continent.^{7,13} To date 13 nations possess the technology, including five who have already detonated a device.⁷ Among the fission products of nuclear blasts are innumerable harmful radioactive isotopes with varying half-lives. Two of the long-lasting and dangerous ones are strontium 90, a bone seeker, and cesium 137, retained by soft tissue, with half-lives of 28 and 30 years respectively.¹¹

The plume of a bomb acts the same as a volcanic plume¹⁴ and encircles the globe, mainly in the same hemisphere, propelled by the prevailing westerly winds. For years it deposits isotopes insidiously in its widening path, gradually increasing the incidence of cancer and genetic mutation both directly and indirectly through food.¹¹ About 85% of the world's population live in the northern hemisphere.

Radiation is an integral part of life but since the weapons-testing years there has been a significant rise in the background radiation rate.¹⁰ Hopefully, this has become more stabilized since the Nuclear Test Ban Treaty of August 5, 1965, and the Threshold Test Ban Treaty of 1976,

with the U.S. and the USSR limiting underground tests to 150 kilotons, and ruling out air and water bursts.⁷

Natural radiation — including cosmic, terrestrial and internal body sources — now total about 80 mrem (milli-roentgens-equivalent-mammal) and man-made sources (including 4 to 5 mrem remaining as fallout from previous weapons testing) about 40 mrem to the total population per year.¹⁰

Our dilemma lies in the field of relative political clout of sovereign governments and continuing deficiencies in our methods of verifying nuclear arms status, even with the aid of modern spy satellites.^{7,15} Perhaps we also should place knowledgeable scientists with empathy in all governments to counsel our political leaders in the basics of nuclear biophysics. A periodic state-of-the-art update and world-wide fallout testing should be established. It is too much to hope that war can be eliminated, but the welfare of our planet must never be placed in jeopardy by the ulterior designs of any single nation or group of nations using the threat of nuclear power. Hopefully and soon, the United Nations, business, religious, ethnic and social groups, the news media and even pen pals can be united in a common cause to end our shameful abuse of nuclear energy before we are forced to learn our lesson the hard way.

In 1939, long before the dawn of the nuclear bomb, Albert Einstein, greatly concerned, prophesied this oft-quoted statement, "The unleashed power of the atom has changed everything except our way of thinking. Thus, we are drifting toward a catastrophe beyond comparison. We shall require a

continued on page 407

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Thoughts on the Nuclear Age

continued

substantially new manner of thinking if mankind is to survive."¹⁶

After a long and satisfying career as a generalist in radiology, I have reason to share these views.

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Roy H. Thompson, M.D., is a radiologist in Euclid, Ohio. Though presently inactive, due to illness, he formerly has served as Chief of Roentgenology, 188th General Hospital, U.S. Army, and as Assistant Professor, Case Western Reserve Medical School.

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* Procordia is indicated for the management of:

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- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA[®]
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Please see PROCARDIA brief summary on adjoining page.

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BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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HERBERT C. FLESSA, M.D.,

Cincinnati, is the new governor-elect for Ohio of the American College of Physicians. Dr. Flessa specializes in leukemia and is professor of internal medicine at the University of Cincinnati Medical Center.

RICHARD RUPPERT, M.D.,

Toledo, was recently named to the board of directors, American Society of Internal Medicine. Dr. Ruppert is president of the Medical College of Ohio at Toledo.

W. HUNTER VAUGHAN, M.D.,

was reelected chief of staff of St. John Medical center in Steubenville. Also elected were NICK TEREZIS, M.D., chief of staff-elect, and SARJIT SINGH, M.D., secretary-treasurer.

JACK L. WALKER, D.O.,

Huron, was elected chief of staff of Sandusky Memorial Hospital. Dr. Walker specializes in otorhinolaryngology.

DAVID O. WIECHERS, M.D.,

Columbus, has been elected to the board of directors of the American Association of Electromyography and Electrodiagnosis, a professional association of physicians engaged in practice and research in electromyography and related neurophysiologic procedures. Dr. Wiechers is currently a clinical assistant professor in the Department of Physical Medicine at Ohio State University, and has a consultative private practice based in Columbus with offices at Grady Memorial Hospital in Delaware and the Medical Center, Chillicothe.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

Hepatitis B vaccine/AIDS correlation?

The mystery of AIDS—and fear of it in the medical community itself—is seen as the main reason many of the government's own doctors and nurses are avoiding hepatitis B vaccination.

AIDS is acquired immunodeficiency syndrome, a collection of symptoms that frequently is associated with homosexuals and intravenous drug abusers. Wiping out the body's defenses against other infections and cancer, it has carried a death rate of 40% of all cases ever reported.

The hepatitis B vaccine, just introduced in the U.S. last summer, is produced from the plasma of chronic carriers of hepatitis B virus.

As with AIDS, most hepatitis B carriers happen to be homosexuals, and most of the plasma for the vaccine thus comes from homosexuals, fueling debate on a possible vaccine-AIDS

correlation, a representative of the vaccine manufacturer Merck Sharp and Dohme said.

Both Food and Drug Administration scientists and commercial developers of the vaccine have concluded that the purification process by which donated plasma is treated makes the benefit of hepatitis B immunity (for people likely to be exposed) outweigh any risk of AIDS.

"It's just so purified there's no way anything could possibly survive in it," a Merck spokeswoman said.

However, VA officials said the scientific analysis appears to have prompted a wait-and-see attitude among some of its health care workers who may be hoping that recently accelerated research efforts to elucidate the cause of AIDS will offer a more definitive guarantee.

First link between exposure to DES in utero and cancer in males

A 28-year-old man whose mother took diethylstilbestrol (DES) during pregnancy has developed testicular cancer. This is the first documented case of such cancer in males exposed to DES in utero, say a group of Boston physicians from Tufts-New England Medical Center in a recent issue of the *Journal of the American Medical Association*.

According to Gene R. Conley, M.D., Grannum R. Sant, M.D., E.R.C.S., Angelo A. Ucci, M.D., and H. David Mitcheson, M.D., diethylstilbestrol, a synthetic estrogen, was used widely in the United States from the early 1940s to 1971 to prevent spontaneous abortion and other pregnancy complications. "As many as four to six million mothers, daughters and sons were exposed to the drug," they write. "Subsequent findings of an increased incidence of clear cell adenocarcinoma of the vagina in the daughters and reports of doubtful efficacy of diethylstilbestrol for the prevention of pregnancy complications led to its discontinuation for that purpose in 1971."

The authors offer three possible reasons for the fact that there have

been no previous findings of testicular cancer in DES-exposed men. "First, patients with testicular tumors are not usually questioned about antenatal diethylstilbestrol exposure and, if questioned, may not know. Second,

common in the 1950s, the group at greatest risk would be expected to be seen in the 1980s. Third, the association may not exist."



the peak incidence of seminoma (malignant tumor in testes) occurs in 30-year-olds, and since diethylstilbestrol exposure was most

Polio cannot be eradicated at present

Participants at an international symposium on polio generally agreed the disease cannot be eradicated at the present time.

In fact, most did not believe the year 2000 would be a reasonable goal to aim for as part of an eradication campaign, Dr. Frederick C. Robbins, president of the Institute of Medicine, said at a press conference.

Dr. Robbins, summarizing the four-day conference here at its conclusion, told reporters the greatest obstacle to eradication is the lack of commitment by some countries, whose leaders do not feel the problem is important enough to "organize themselves the way we organized to eradicate smallpox."

Emergency medical system is organized nationwide

A National Disaster Medical System (NDMS) is being established across the United States to provide an organized means of coping with a major emergency.

The system will use as its foundation the Civilian-Military Contingency Hospital System (CMCHS), developed by the Defense Department to reserve space in civilian hospitals for the large numbers of military casualties expected to be returned to the United States during the early stages of an overseas conflict.

"The NDMS system will have two purposes," says Thomas Reutershan, emergency coordinator for the Public Health Service: to care for civilian casualties of a major peacetime disaster, and to care for military casualties from an overseas conventional conflict in the event the DoD system is overloaded—the same purpose as CMCHS.

The system now being created will differ in several respects from CMCHS, Reutershan says, though "it is anticipated that hospitals which have signed agreements under the CMCHS system will be asked to modify their agreements to join the new NDMS system."

NDMS will have three principal components, he said:

- Providing assistance at the scene of the disaster. Civilian "disaster medical assistance teams" will be established using volunteers from the federal, state, local and private sectors.

- Patient evacuation. "We're looking, obviously, toward the military, which have aircraft that can be used for that purpose — the C-9, C-141, C-130," Reutershan said.

- "We're also going to be looking, though, at the possibility of using commercial passenger jets — how they might be configured to carry stretcher patients — passenger trains, school buses, all kinds of transportation modes."

- Definitive care. "In addition to the metropolitan areas currently included in CMCHS, and the hospitals in those areas, which now total a little over 56,000 beds, we have established a goal for the NDMS of 100,000 beds."

The plan for NDMS, Reutershan said, is to use existing resources "to the maximum extent possible."

As a consequence, he added, the system is expected to cost virtually nothing until it is activated.

"The prime responsibility for responding, for dealing with disasters, remains with local and state officials.

The system is in no way designed or conceived to supplant that," Reutershan observes.

The system can be activated in two ways, he says: if the President declares a disaster and has a request from a state governor for medical assistance, or if a national security emergency occurs.

New life insurance company to serve midwest physicians

American Physicians Life Insurance Company, a regional life insurance organization, has been formed to serve the life insurance and financial security needs of physicians throughout the midwest. American Physicians Life was formed March 2, 1983, by Physicians Insurance Company of Ohio (PICO) through the merger of two subsidiaries, PICO Life and Indiana Physicians Life Insurance Companies.

American Physicians Life already serves physicians in Ohio, Indiana, Kentucky and Michigan and plans to establish operations throughout the midwest. American Physicians Life has gained the endorsement of three state medical associations, the Ohio State Medical, the Indiana State Medical and the Kentucky Medical Associations, and also is supported by physician-owned medical malpractice insurance companies in Ohio, Kentucky, Indiana and Michigan.

The merger action involved the formation of a new Ohio holding company, The Physicians Investment Company, as the parent company of American Physicians Life. Ownership of Indiana Physicians Investment, the holding company for Indiana Physicians Life, and PICO Life was transferred to the new holding company.

As the sole previous owner of PICO Life and the majority owner of Indiana Physicians Investment Company, PICO became the majority owner of The Physicians Investment Company. Sharing minority ownership positions are the Indiana State Medical Association, the Kentucky Medical Insurance Company and Physicians Insurance Company of Michigan, each

representing physicians in their states.

There are several reasons behind the formation of American Physicians Life. As the sole previous owner of PICO Life and as the majority owner of Indiana Physicians Investment Company, it became appropriate for PICO to merge the two life insurers into a stronger, single entity. The merger also allowed for the consolidation of the two life company operations which allows American Physicians Life to concentrate more strongly on its primary objective of serving the life insurance financial security needs of physicians and other professionals and their corporations.

Currently, American Physicians Life offers physicians in Ohio, Indiana, Kentucky and Michigan a comprehensive product portfolio designed to serve their specialized life insurance and financial planning needs. In addition to its competitive life insurance product line, American Physicians Life offers a variety of disability income coverages, qualified pension plan programs and tax-deferred annuities. American Physicians Life is also the underwriter of several medical association-sponsored group life and health insurance plans. Several of these group plans, including group term life insurance, will be offered to medical association groups in the states. American Physicians Life plans to enter.

For more information about American Physicians Life or its services, contact the home office at Bates Drive, P. O. Box 281, Pickerington, Ohio 43147 or phone (614) 864-3900, or toll-free in Ohio, 1-800-282-7515.

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When you're asked to compare the price of your medical professional liability insurance coverage, we suggest that you also compare quality. When your claim arises, now or several years in the future, the quality of your coverage, claims services, and the company standing behind you is what really matters.



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OHIO STATE MEDICAL ASSOCIATION

Indulging .. to the Point of Destruction

By John J. Newton, M.D. and the OSMA Committee on Cost Effectiveness

The continuing, flagrant abuse of tobacco, alcohol and drugs may be costing more than you think . . .

We have been hearing a lot of conversation over the last several years about the benefits associated with avoiding disease rather than addressing an illness once it has become established. The benefits accruing to the maintenance of good health obviously are very significant. Good health allows us the privilege of being active and creative as well as possessing a sense of well being. In other words, good health allows us to function as complete human beings. We also could point out that good health saves money.

There are several areas, however, where we indulge ourselves to the point of destruction. Solving the problems of abuse in these areas would add millions of years to our lives as a population, save us many billions of dollars, and increase our productivity as a society. The areas that cause particular concern include alcohol and other substance abuse, tobacco, diet, and to a lesser extent, stress. As is usual, when we are addressing difficult problems, the solutions are not easy.

Alcohol has been known to our society and all societies since long

before recorded history. Our civilizations have grown up with it and look upon it as a relatively benign substance that enhances the quality of life and for most, this may well be true. In fact, there is evidence that drinking a maximum of two ounces of absolute alcohol daily elevates the Serum HDL and thereby protects to some extent against arteriosclerotic cardiovascular disease. However, the problem of abuse of alcohol and drugs

If trends continue as they are at present, alcohol and drugs will constitute our number one health problem in 1990 . . .

in our society is becoming so immense that it no longer can be ignored. If trends continue as they are at present, alcohol and drugs will constitute our number one health problem in 1990.¹

Ten percent of all deaths in the country are alcohol-related. It is estimated that 25% of hospitalizations in community hospitals are in some way alcohol-related. This percentage goes up to 40% to 50% in VA hospitals. These statistics do not even address the disruptions of individual and family lives, the poor work performance, and numerous other community negatives which are associated with the heavy use of alcohol.

It is important, perhaps even urgent, that we as physicians think about alcohol and alcoholism in a great many of the patients that we see. This is not to say that most may be alcoholic, but it seems that alcohol has replaced syphilis as the great imitator of other diseases in the late 20th century. A study done on Navy personnel documented a much greater use of hospital facilities by heavy users of alcohol than by abstainers or light drinkers — although their patterns of illness were indistinguishable from those experienced by the light drinker and abstainer population. Thus, we see that while alcoholics are

continued on next page

hospitalized with the same illnesses and in the same general patterns as nonalcoholics, their hospitalizations are much more frequent.²

As more facts are documented regarding the actions of alcohol on the body, we may begin to detect deleterious effects on even nonaddictive levels of alcohol. One example of this is the fetal alcohol syndrome. Six drinks per day by a pregnant woman gives her a 10% to 12% chance of having a child with fetal alcohol syndrome. Another example that seems to be evolving is in the immune system. It appears that the actions of alcohol on the bone marrow and/or white blood cells may result in increased susceptibility to infections when the use of alcohol may be heavy but at less than addictive levels.

Tobacco is another drug used widely in our society, that has multiple and severe deleterious effects on the body and on life expectancy. As with all addictions, this heavy use continues, even when evidence points to tobacco as the cause of these effects. Smokers drink more alcohol, coffee and tea than do nonsmokers. Their weight and blood pressure are slightly less and their heart rate is slightly faster than those of nonsmokers. Menopause comes earlier in women who smoke than in those who do not. Smokers have impaired maximum exercise performance. Taken as a whole, cigarette-smoking men have 30% to 80% higher death rates than nonsmokers. Premature coronary heart disease is one of the most important consequences of cigarette smoking. The risk of fatal or nonfatal coronary heart disease is 60% to 70% greater in male smokers than nonsmokers. Sudden death may be the first manifestation of coronary heart disease and is two to three times more likely in 35- to 54-year-old smoking males than in nonsmokers. Women who smoke cigarettes and use oral contraceptives increase their risk of suffering an acute myocardial infarction more than fivefold. Cessation of smoking is associated with decreased coronary heart disease mortality, an effect which is

measurable within one year.

The risk of developing lung cancer is quantitatively related to cigarette smoke exposure. Men who smoke one pack a day increase their risk tenfold compared with nonsmokers. Men who smoke two packs a day may increase their risk more than 25-fold compared with nonsmokers. Cigarette consumption by women in the past 25 years increased in the United States and lung cancer mortality currently is increasing at a faster rate in women than in men. Fifteen years after giving up cigarettes, the ex-smoker's risk for cancer of the lung approximates that of a nonsmoker. Carcinoma of the oral cavity larynx, esophagus, and bladder also are associated with cigarette smoking. Smokers experience four to 25 times higher mortality rate secondary to chronic obstructive pulmonary disease than do

Many of us carry in our lifestyles habits, addictions, indulgences which are as costly in terms of suffering as in the literal dollar sense . . .

nonsmokers. Subtle pulmonary function abnormalities may be present even in teenage smokers.

The infants of mothers who smoke during pregnancy weigh on an average of 170 grams less than infants whose mothers did not smoke. Maternal smoking during pregnancy is related to an increase in early fetal and neonatal deaths.³

Issues about the relationship between diet and health continue to be somewhat blurred. It appears that diets that are low in animal fat are helpful in controlling high lipid levels in certain types of hyperlipidemia. It appears that there is a definite

relationship between diets low in dietary fiber and the subsequent development of diverticulosis of the colon. The relationship between diets low in fiber and the subsequent development of human colon carcinoma has been postulated but thus far has not been completely substantiated. Diabetic patients treated with high fiber diets may experience a change in the glucose tolerance and require downward adjustment of their insulin doses. Obesity is associated with increased incidents of arteriosclerotic disease, hypertension, diabetes mellitus, and osteoarthritis, to mention but a few of the associated risks.

A brief comment also might be made regarding stress. Obviously not all stress is bad; in fact, most stress stimulates us to perform appropriately. This type of stress is referred to as **eustress**. The disagreeable or pathologic stress is referred to as **distress**. Volumes have been written on this subject but our current concerns are directed largely at the aggravation of arteriosclerotic heart disease, which may be associated with inappropriately severe stressful situations applied over a long period of time.⁴ Some recent work suggests that hostility, applied over some period of time, may be a particularly destructive form of stress reaction.

We can see from the above that many of us carry in our lifestyles habits, addictions, indulgences or whatever labels we may care to apply, that which is inimicable to good health and long life. They are costly also in terms of suffering and inconvenience to those around us, as well as in the literal dollar sense. Unfortunately, glib assertions and exhortations on prevention or responsibility miss the point and may be even counterproductive. However, there is value in promoting specific preventive strategies such as hypertension identification and control or immunization. The more complex behavior patterns, those related to eating, substance abuse, exercise, and so forth are extraordinarily difficult to change, even when the individuals involved are motivated.

It is important to realize that successful health promotion cannot be based on superficial and isolated efforts to improve health behavior in one realm or another. The evidence is impressive that isolated efforts to change behavior, whether diet, smoking, or preventive medical care, produce short-term change, but change that almost never persists over time without reinforcement and continuing facilitation. The strongest type of facilitation is to successfully integrate desired behaviors as part of the culture of natural supportive groups. Behavioral change is more likely to occur if it is expected and socially reinforced, preferably by close personal associates, but also in the broader social contexts.

In many instances the promotion of health is more likely to be successful through technological or regulatory

means than through behavior change. If we wish to reduce accidents and deaths among teenagers, we do better by delaying the legal age of driving than by driver's education. Even the most elaborate campaign for seat belt use achieves only modest success. Automatic safety devices frequently offer greater benefits at lower cost. In practice, we usually end up with an approach with some mix of education, technology, and regulation. Whatever the issue, a strategy that calls upon a number of methods simultaneously offers the best possibility, particularly when the noxious behavior is one that is personally and socially rewarding in some way. It is also clear that we do better to prevent noxious behaviors initially in contrast to altering them subsequently. Behavior initially adopted for social reasons or in response to peer pressures may

become addictive or associated with complex behavioral patterns that are extraordinarily difficult to alter.⁵

Targeting high risk groups is a sensible priority, however, and while it is commonplace to give lip service to the role people have in their own health and the importance of health promotion, efforts to understand the causal processes affecting these behaviors and to evaluate the impact of varying strategies to prevent or change such patterns still receive little public attention. A model of health education and promotion based on sound principles of intervention offers as much potential for health maintenance as any curative medical technology. A long and vigorous life that is productive and satisfying and which terminates in a brief illness is the ultimate goal of health promotion efforts. The first step in achieving any goal involves defining the problem and looking at strategies for addressing it.

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John J. Newton, M.D., is a member of the Committee on Cost Effectiveness and has a general practice in Toledo, Ohio.



One from Many

By Karen S. Edwards

A single, broad-based medical community like the OSMA is comprised of many specialties . . . many parts which add up to the whole.

E Pluribus Unum. One from many.

So much of what exists today exists as a sum of its parts. Certainly Benjamin Franklin, John Adams and Thomas Jefferson recognized this when they chose the "E Pluribus Unum" motto for the United States.

The motto was finally adopted in June, 1872, and perhaps it is somewhat fitting that exactly 100 years later, the Ohio State Medical Association (OSMA) began to take a look at its own "E Pluribus Unum" position.

A single, broad-based medical community like the OSMA is comprised of many parts, many specialties which, in fact, are communities in and of themselves. Long sensitive to this fact, the OSMA began to take some initial steps in 1972 toward recognizing and responding to the needs of the specialty societies in Ohio. What has evolved in the last eleven years is a mutually beneficial relationship — one in which the parties give and receive, while ultimately making each other strong.

What the OSMA offers the specialty societies is a sense of permanency. . . a chance for each society to preserve its own unique character through the Association's wide scope of services.

For example, the OSMA can offer each specialty society:

- A permanent address and phone number. No small contribution in view of the fact that many societies change these annually with each president — a move which often can confuse and frustrate society members.

- A permanent repository for records. No more cardboard boxes relegated to the basement of the member who is currently serving as society secretary.

- A well-trained staff, working exclusively for, and sensitive to the needs of the specialty societies, as well as assistance from OSMA personnel in other departments, such as legislation, government relations, and communication.

- Access to creditable providers. The staff acts as liaison with reputable printers, office suppliers, hotels, caterers, other providers that may be needed.

- Computerization of membership.

The OSMA currently serves 11 specialty societies with a combined total membership equaling more than 6000 physicians.

- Coordination of legislative and communication activities.

- Access to more sophisticated equipment than probably would be available to each society as an individual organization.

- A closer identification with the OSMA itself.

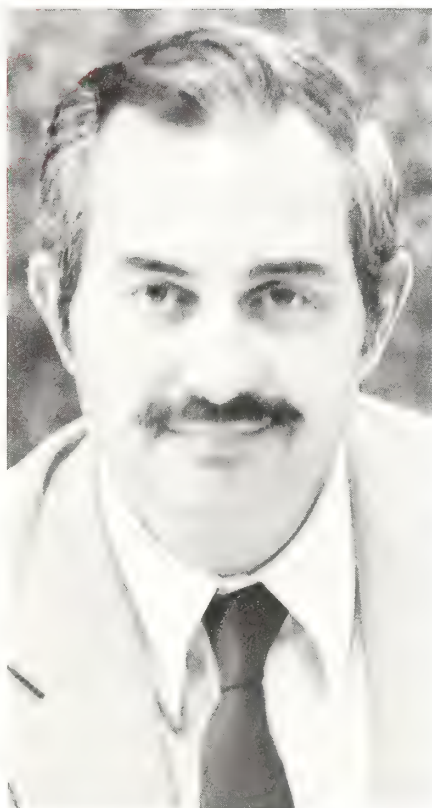
"The OSMA currently serves 11 specialty societies with a membership of more than 6,000 physicians," says Vickey McVay, Assistant Director for Specialty Society Services.

Three full-time and two part-time employees comprise a team which provides day-to-day administration of business for the societies.

"I'd estimate that about 25% of our



The staff of the Department of Specialty Society Services. Left to right: Anita Metheny and Lori Evans.



Jerry Campbell



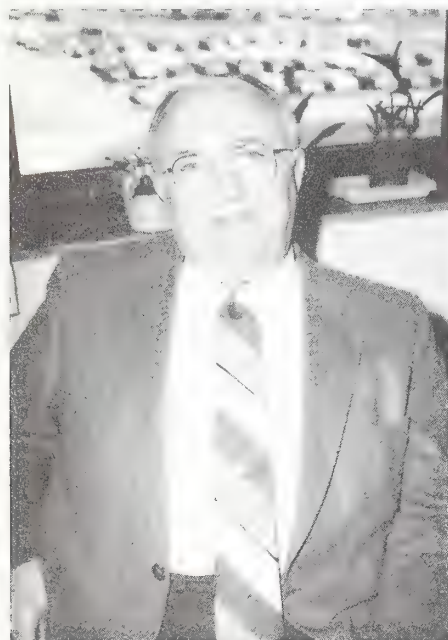
Vickey McVay

What the Specialists Say

How well is the OSMA meeting the needs of the specialty societies it serves? According to two specialists we asked, their group's needs are being met very well, indeed.

"A few years ago, when our College recommended a restructuring of our by-laws, we had a difficult time locating a copy of them. That's when we decided we needed a central repository for our records — someplace where we could always know where they are, and that they are safe," says Robert K. Finley, M.D., a surgeon in Dayton, and a member of the Ohio Chapter, American College of Surgeons, one of the specialty groups served by the OSMA.

According to Dr. Finley, avoiding the town-to-town search for important documents, including an original charter, is one of the biggest reasons the group came to the OSMA. However, there are other reasons.



Nicholas DiPiero, M.D.

"We use the mailing facilities that are offered to us, and their meeting planning skills," he says. "And we find the OSMA's central location in Columbus a convenience."

Location was also a reason — in fact, a pivotal reason — for the Ohio Society of Anesthesiologists to contract with OSMA's Department of Specialty Services.

"We felt the time had come when we had to be located in Columbus — to keep a close watch over the health care legislation going on at the Statehouse," says Nicholas G. DePiero, M.D., an anesthesiologist in Cleveland, and current Secretary-

"We felt the time had come when we had to be located in Columbus — to keep a close watch over the legislation at the Statehouse."

Treasurer of the Ohio Society of Anesthesiologists.

"When problems come up which are of concern to us, we want to know about them before it's too late to do something about them," Dr. DePiero says.

Although Dr. DePiero doesn't describe the group as "politically active" he says that they do keep close track of legislative activities through their OSMA liaison, and they testify when necessary.

"The OSMA serves as a feeder, giving us the legislative information we need," Dr. DePiero adds.

"It's much better than when we were on our own and had no liaison — no information at all." — Karen S. Edwards.

time is spent on Annual Meetings," McVay says. Four of the larger societies use the OSMA Specialty Society exclusively for planning their Annual Meetings — and that includes everything from site visitation to staffing the registration desk at the meeting.

But Annual Meetings are, as McVay has indicated, only a part of the job.

The staff bills members for their dues and deposits any money they receive for the societies (from dues or registrations) into the proper accounts. They assist in credentialing new members, type meeting agendas, update rosters.

"We'll also write newsletters and

The Specialty Society Services staff keeps a daily record of all the work that is done, so that each society has a carefully documented record of what they're paying for.

take minutes at board meetings," McVay says. Their jobs are as flexible as the needs of their members.

"What we're basically offering is executive secretarial services," McVay says.

"The beauty of it," says Jerry Campbell, Director of the Department, and an OSMA Associate Executive Director, "is that the societies only pay for those services they receive."

The Specialty Society Services staff keeps a daily record of all the work that is done, the amount of time spent on each project, and for whom the services were provided. This way, each society has a carefully documented record of what they're paying for.

"This type of system is really very cost efficient for the societies," Campbell adds. "And too, they can

avoid the cost of any major capital expenditures since the OSMA is responsible for upgrading and purchasing equipment when necessary."

The OSMA began its foray into providing services for specialty societies earlier than most associations.

"We spent two days in Texas studying a plan which the Texas Medical Association was using, then came back and prepared our own contract," Campbell says.

Since then, OSMA's contract has been used as a model throughout the country.

"One of the things we stress is that our services always stay consistent," Campbell says. "Any service offered to one society is offered to the others."

"Of course, that sometimes creates a challenge in establishing priorities," McVay says, "but we never tell the societies, 'No, that can't be done.'"

One of the biggest boosts of goodwill in this special relationship between the societies and the OSMA is the Association's recent move to allow the specialty societies a separate seat — a vote — in the OSMA's House of Delegates.

Besides the obvious benefit the OSMA receives in its membership roles, there is a philosophical and functional attachment of specialty societies toward the OSMA, which results in a much stronger foundation for the Association.

"There does seem to be a strong allegiance toward the OSMA from our specialty society members," McVay comments.

The fact is, too, that once a society has joined the OSMA's ranks of "societies served," they stay. "Every specialty society that OSMA has ever contracted with has chosen to renew their agreements," Campbell says, and, in fact, all the conditions seem to be ripe for expansion in this area.

"We're currently negotiating a contractual agreement with one long-established society and feel that there are several other state specialty societies that could benefit from this service," McVay says.

Campbell echoes the sentiment.

"We are keenly aware of new opportunities for growth," he says.

Growth in the number of specialty societies served can only make the

OSMA and the specialty societies stronger and fuller.

Where there is mutual responsibility, there is mutual respect and mutual strength. The sum of all parts becomes one, in purpose and ideal. What exists between the specialty societies and the OSMA is a very special relationship. E Pluribus Unum.

Following is a list of those specialty societies which the OSMA presently serves.

If you are interested in learning more about what the OSMA can do for your specialty society, please contact: The Department of Specialty Society Services, The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

Specialty Societies served by the OSMA

Ohio Chapter, American College of Surgeons

Ohio Committee of Trauma, American College of Surgeons

Ohio Ophthalmological Society

Ohio Orthopaedic Society

Ohio Society of Allergy and Immunology

Ohio Society of Anesthesiologists, Inc.

Ohio Society of Internal Medicine

Ohio Society of Otolaryngology

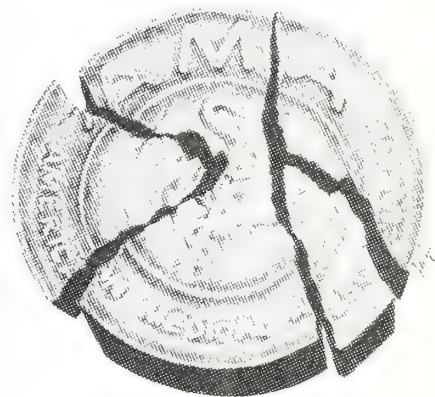
Ohio Society of Pathologists

Ohio State Neurosurgical Society

Ohio State Radiological Society

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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OSMA's Medical Student Section Officers for 1983-1984



Alan T. Mong President

Following his graduation from Ohio Northern University in Ada, with a bachelor of science degree in biology and a bachelor of arts in chemistry, Alan T. Mong enrolled in the Ohio State University's College of Medicine. He expects to receive his M.D. degree in 1985.

During the summer of 1979, Mr. Mong served as a pathology assistant at Piqua Memorial Hospital. More recently, he has completed training, and a surgical clerkship with the United States Naval Reserve Medical Corps, where he holds the rank of ensign.

A past volunteer with the Ohio Cancer Information Service, Mr. Mong also has been active in academic groups, serving on an intra-fraternity council, and on the Liberal Arts Student Council at Ohio Northern. A previous secretary for OSMA-MSS, he also has served as OSU's delegate to AMA-MSS.

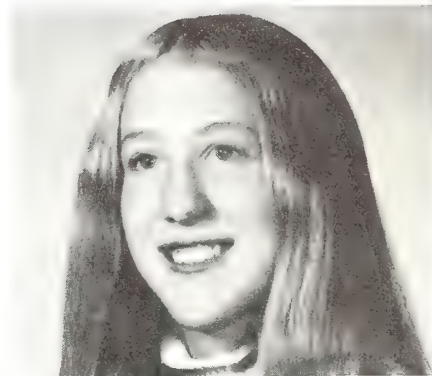
Among other honors and awards received by Mr. Mong are the Swartz Scholarship and the Hawbecker Memorial Award.

David L. Roer Vice-President

David Roer received his bachelor of science degree in biology from the State University of New York (S.U.N.Y.) at Binghamton, and his master's degree in genetics from Ohio State University, before entering Wright State University's School of Medicine in Dayton, Ohio. He expects his M.D. degree next year.

Mr. Roer has been a teaching assistant in the department of biology at S.U.N.Y. and has served as premedical/predental academic advisor at Ohio State University.

An active participant of both service and academic groups, he has been graduate student president for the department of genetics at OSU; has served as Wright State University's delegate to AMA-MSS, and to OSMA-MSS (where he participated last year as a governing council member); and has served as Treasurer of Wright State Medical School's Student Council. He has also served as a Community Activities Board Member at Wright State.

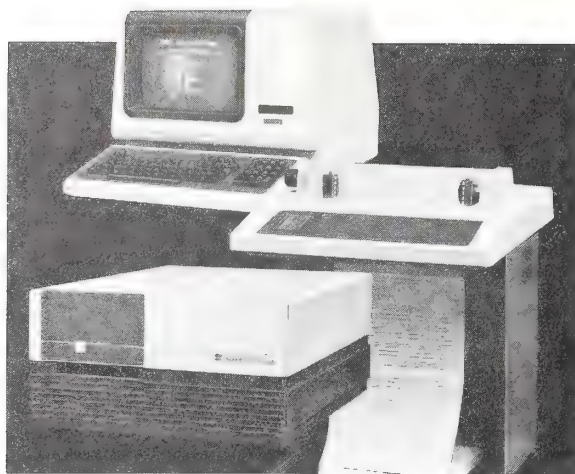


Linda Elaine Weber Secretary

Born in Cleveland, Ohio, Ms. Weber graduated magna cum laude from Case Western Reserve University with a B.A./M.A. in psychology. She is presently attending Ohio State University's College of Medicine from which she expects to receive her M.D. degree in 1985. Her previous work experience includes positions as a psychiatric aide at Windsor Hospital; research assistance in the pharmacology departments at both OSU and Case Western and in the child psychiatry department at OSU. She is currently working as a medical assistant in clinical pharmacology at OSU.

Active in OSU's Medical School's Student Council, Ms. Weber has served as both class president and vice-president, as well as class representative. She was an OSU delegate to the AMA-MSS in 1981, and has served as OSU delegate and secretary to OSMA-MSS since 1982.

Ms. Weber is the recipient of numerous awards and honors, including: Western Reserve Scholar, the Rusoff Award for Academic Achievement and the American Heart Association East Ohio Affiliate Summer Research Stipend Award.



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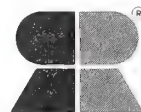
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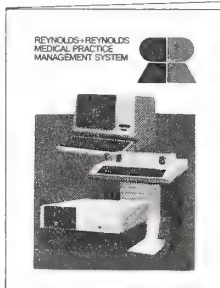
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profiles

Sir Arthur Conan Doyle and His Mystical Ohio Tour

By James G. Ravin, M.D.

What prompted the prominent physician-turned-author to dabble in the strange world of mysticism . . . right here in Ohio?

Sir Arthur Conan Doyle, physician and author, came to Ohio twice, in 1922 and 1923. Doyle is best known as the creator of one of the most famous characters in fiction, Sherlock Holmes. His purpose in visiting Ohio was to speak on behalf of spiritualism.

Doyle was born in Edinburgh, Scotland, in 1859. He graduated from the University of Edinburgh Medical School, receiving his Bachelor of Medicine and Master of Surgery degrees in 1881, and his Doctor of Medicine degree in 1885. While in medical school he began submitting short stories to various magazines. Many were published. Writing earned this impoverished medical student more money than did other available jobs, such as filling vials with medications. After graduation he opened a general

practice in Southsea, England, in 1882, but the practice was never very active. His first Sherlock Holmes story, "A

Doyle ended the life of his hero at Reichenbach Falls, Switzerland . . . "a worthy tomb for poor Sherlock, even if I buried my bank account with him . . ."

Study in Scarlet," was sold for 25 pounds in 1886. This was a terrific bargain for the publisher, for it became

a great success. Doyle eventually wrote 60 Sherlock Holmes detective stories. However, he preferred to write historical fiction in the style of Sir Walter Scott. This latter type of story had some popularity, but the public greatly preferred the detective, Sherlock Holmes. Doyle was concerned about being too closely identified with one character, and in 1892 ended the life of his hero at Reichenbach Falls, Switzerland, a place he "thought would make a worthy tomb for poor Sherlock, even if I buried my banking account with him."¹ The reading public was greatly distressed. Some Londoners wore mourning bands to work. But Doyle refused to write another Sherlock story for eight years.

In 1901 he wrote *The Hound of the Baskervilles*, a reminiscence of



Sir Arthur Conan Doyle

Conan Doyle Here Tonight

Sir Arthur Conan Doyle, creator of fiction's most famous sleuth, Sherlock Holmes, and now the most noted exponent of spiritualism, will lecture at Memorial Hall Wednesday night on "Recent Psychic Evidence."

He also will display the much discussed spirit photographs and photographs of ectoplasm, newly discovered substance which, he claims, is given off by mediums and frequently takes the human form.

This ectoplasm, he believes, is the connecting link between this world and the world of spirits.

Sir Arthur's spirit photographs have been branded in many quarters as frauds, mere photographic tricks.

One picture he claims to have taken, shows what he says are spirits gathered about the tomb of the unknown soldier in London during the last Armistice Day ceremonies.

— Columbus Citizen
April 25, 1923

Sherlock Holmes, which he dated as occurring before the affair at Reichenbach Falls. *The Hound* was an astounding success. The publisher could not print enough copies. People lined up outside the publisher's office to buy copies right off the press. Encouraged by this response, Doyle intermittently wrote more stories about his famous detective. The last of the 60 Sherlock stories was written in 1927, about 40 years after the first one was penned and three years before Doyle's death.

Doyle came to feel he was wasting his life as a physician in the provinces . . . he decided to give up his general practice and study ophthalmology

Doyle came to feel he was wasting his life as a physician in the provinces. After a long talk with a colleague in 1890, he decided to give up his general practice and travel to Vienna and Paris to study ophthalmology. Upon returning to England, he opened an office for the practice of ophthalmology in the center of London. No patients ever came to see him, but this offered him time to write, and he earned a fine living with his pen.

About 1886 he became interested in spiritualism. He came to believe that communication with the dead was possible and he read everything he could find about psychic science. According to Doyle, the most famous spiritualist medium in America was Miss Ada Besinnet of Toledo. She had spent six months in England in 1921 on the invitation of the British College of Psychic Science, and she gave over 60 seances there. Sir Arthur and Lady Conan Doyle attended four of her seances. They were greatly impressed and invited her to their Sussex home

This story on Doyle's visit to Ohio appeared in a Columbus paper.

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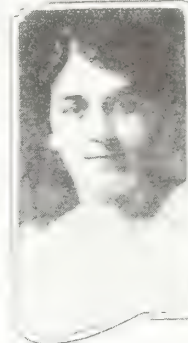
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Sir Arthur At Toledo Medium's Seance

S

Movie Secrets

PRaised BY SCIENTIST



MARBLE GAMES EVERY DAY

Clare On The Day Before Seance

HOUSES FOR SALE

Are Told To Take More Interest In Schools

The now-defunct Toledo News-Bee took this rather sensational approach to Doyle's experiences with mysticism

for a weekend. Reporting his absolute confidence in her character, he wrote of her materializations:

In three cases, that of my mother, of my wife's mother, and of my nephew, the likeness was absolutely startling, and was seen so clearly and so coolly, that I could take my oath upon it in any Court of Law.²

In 1922 Doyle travelled to America for the first of two extended speaking tours in behalf of spiritualism. His itinerary included a lecture in Toledo. He spoke for two hours on "The Proof of Immortality" before a capacity audience of over three thousand people. Doyle expressed the belief that spiritualism was the most important subject in the world, that:

Either this revelation is the greatest delusion ever known or it is the greatest advance that the world has ever made. It is for me to lay the facts before you and for you to act as the jury, whose verdict I am prepared to accept.³

Doyle included Toledo in his itinerary specifically because it was the home of Miss Besinnet, and he stayed an extra day after his lecture to attend one of her seances. He found Toledo "a very rising and beautifully wooded town." He "appreciated the wonderful suburbs with their miles of luxurious villas, filled with the most extraordinary mixture of architectural styles." The three Doyle children enjoyed watching a lake freighter being filled with coal. They stayed at the Secor Hotel, whose accommodations were "extraordinarily



Miss Ada M. Besinnet

Toledo mystic Ada Besinnet

continued on page 431

**HYPERTENSION
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AND MORE.**



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INDERAL, a logical first step

Unlike thiazide diuretics, which can provoke serious reductions of serum potassium, INDERAL has been found to maintain or modestly increase serum potassium levels!^{1,2} Therefore, the consequences of hypokalemia—including the threat of ventricular arrhythmias²—may be significantly reduced.

INDERAL acts to reduce catecholamine-induced "spiking" of blood pressure which often coincides with the physical and emotional stress in a hypertensive's life.³ INDERAL reduces elevated heart rate, force of ventricular contraction, and cardiac work load—providing smooth control of hypertension to decrease the risk of related cardiovascular complications. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.)

INDERAL works in a way that non-beta blockers can't—to provide long-term cardiovascular benefits.

INDERAL provides treatment for coexisting angina pectoris or cardiac arrhythmias in addition to reducing blood pressure—for comprehensive protection. What's more, INDERAL is well tolerated, acting with few of the distressing side effects of antihypertensive agents such as methyldopa or reserpine. Impotence, depression, sedation, orthostatic hypotension, and nasal stuffiness are rare. (Please see following page for Brief Summary of Prescribing Information, including side effects of INDERAL.)

Indeed, INDERAL has changed the face of antihypertensive therapy, worldwide. And it continues to do so—with an unparalleled record of clinical efficacy and experience.

INDERAL. It's the kind of protection hypertensive patients need—right from the start.

References: 1. Traub, Y. M., et al.: Clin. Pharmacol. Ther. 28:765 (Dec.) 1980.
2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. 647 (Suppl.):67, 1981.
3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

INDERAL

(PROPRANOLOL HCl)

Comprehensive Cardiovascular Protection

Please see following page for brief summary of prescribing information.

INDERAL[®]

(PROPRANOLOL HCl)

CORE THERAPY
FOR ANGINA.



The appearance of these tablets is a trademark of Ayerst Laboratories

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
Inderal[®] (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS,

EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure; intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory** bronchospasm. **Hematologic** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

— Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).
— Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).
— Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).
— Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-99).
— Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTION

— Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).
Store at room temperature (approximately 25° C).

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

8225/483

good" and noted that the hotel had a "hall and vestibule which would compare for elegance with many in London."⁴

During the following year, 1923, Doyle again toured America speaking on behalf of spiritualism. His itinerary included lectures in Cleveland, Columbus, and Cincinnati, and a visit to Toledo for a seance with Miss Besinnet.

As soon as his ship docked in New York, he was deluged with reporters. The reporter for the *Cleveland Plain-Dealer* quoted Doyle as saying "this question of psychic investigation, of the future life, is the most important thing in the world."⁵ After giving several lectures in New York City, Doyle travelled to Cleveland. He visited a downtown hotel where a dance marathon was in progress and a new world endurance record was being set. The fatigued competitors had danced for 60 hours, while the winner was to continue for 40 hours more. He watched with curiosity as the dancers had their eyes syringed to relieve irritation. Doyle found Cleveland a "noble" but grim city of iron and shipping. He felt that "busy, material places" like Cleveland were where the "spiritual message is most needed."⁶

The lecture in Cleveland was covered on the front page of the *Plain-Dealer* for April 19, 1923:

A place of perfect bliss, where all ambitions are realized, where the old grow young again and the young grow to manhood, abounding with flowers, books, beautiful streets and beautiful buildings-

This was the picture of the land beyond the grave inhabited by the spirits of the dead, drawn last night by Sir Arthur Conan Doyle in his lecture on spiritualism at Masonic Auditorium.

Fortifying with photographs of what he said were spirits, his argument that the spirits of the dead return to this world and communicate with their living friends, Sir Arthur drew gasps of astonishment from

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his audience, which nearly filled the big auditorium.

A majority of the audience were women. However, none fainted, and there was no audible sobbing, such as reported at his first lecture in New York.⁷

His next lecture was in Pittsburgh. The route from Cleveland reminded him of Dante's circles of descent into hell. Pittsburgh seemed similar to the "dreadful" industrial cities of northern England.⁸

Cincinnati was the next stop. Doyle called it "a very busy commercial place."⁹ In Cincinnati he found much interest in spiritualism. It was the home of Mrs. Pruden, a famous medium who specialized in slate writing. He attended one of her seances. All the questions he asked her were answered on the inside of closed slates. Doyle was most impressed.

An editorial writer for the *Cincinnati Post* welcomed Doyle "as the creator of Sherlock Holmes and of the faithful

Dr. Watson," saying "they were more convincing individuals than any spirit"¹⁰ he had ever seen materialized. The *Cincinnati Enquirer* found "the real Sherlock Holmes unconcerned about his attire, contemplative, yet alert and true to his literary form except that he is stout and genial instead of tall, thin and quizzical."¹¹

Doyle travelled to Columbus where he spoke on the subject "Recent Psychic Evidence." He projected several "spirit photographs." Doyle said one of these showed his son who had died in World War One, and another depicted a group of "spirits" around London's tomb of the unknown soldier. The Columbus newspapers took a neutral stance on this, and did not give Doyle as much coverage as did the other Ohio cities where he spoke.^{12,13}

After speaking in Columbus, Doyle travelled to Toledo for another seance with Miss Besinnet. He described his

Kindred Spirits

What's the link between an OSMA member alive and well and practicing in Toledo and an English ophthalmologist dead more than 50 years? The answer, my dear Watson, is elementary. Sherlock Holmes, fiction's most erudite detective, has captured imaginations since his creation by Sir Arthur Conan Doyle nearly 100 years ago. James G. Ravin, M.D., an ophthalmologist from Toledo, is no exception.

His interest in Holmes has gotten him involved in a wide range of pursuits. He is a member of one of the scion societies of the Baker Street Irregulars — an international group dedicated to Holmes. Membership in that group which is composed of 60 members — one for each of Doyle's 60 stories about Holmes, is so coveted that one must wait for a member to die before being admitted. The Toledo group of which Dr. Ravin is a member

meets monthly to talk, compare notes and test each other's knowledge about the famous sleuth.

Dr. Ravin's interest also led him to purchase a collection of Doyle's correspondence. The collection includes 18 letters from Doyle to Ada Besinnet (a Toledo spiritualist), two of his calling cards, a letter from Lady Conan Doyle, six letters from Harry Houdini (who also had an interest in spiritualism), newspaper clippings, theatre playbills and such. And, the story printed in this issue of the OSMA Journal is just one of the many articles penned by Dr. Ravin about Doyle and his creation. His credits include articles in the Baker Street Miscellanea and The Baker Street Journal.

All in all, it's a challenging avocation and a fitting one for an ophthalmologist interested in writing.

Carol Wright Mullinax

excitement in *Our Second American Adventure*:

We were greatly favored that evening, for we had the whole gamut of the medium's powers, the powerful voices, the wonderful musical performances, the brilliant lights, the fitful materializations, the written messages, the continuation of the songs when a bandage was over the lady's lips, and finally the whole heavy table was lifted bodily into the air. It was a very impressive exhibition.¹⁴

Doyle began writing his memoirs of the 1923 tour of America while travelling through rural Ohio. This sophisticated Englishman described the countryside:

Consider the case of these Ohio farmers, who are more lucky than most. You see their homesteads in the fields, bare and unattractive. The city is afar. Of walks or

natural beauties there are none. A long winter of dullness leads up to a hardworking year, busy from early morning to late at night, and with so little to show for it that I am told the majority of the farms are deeply mortgaged; and yet these are the kings among men compared with the average fate of their fellows.¹⁵

Sir Arthur was in his sixties at the time of his visits to Ohio in 1922 and 1923. He was to live until 1930. He was an honest, sincere man, who put his reasons for speaking on behalf of spiritualism as follows:

At my age I am in a position where I have nothing either to fear or to hope for from any world source. I desire nothing further that the world can give me, and I dread nothing which it can either do to me or say of me. Therefore, my one desire is to say exactly what I believe to be true.¹⁶

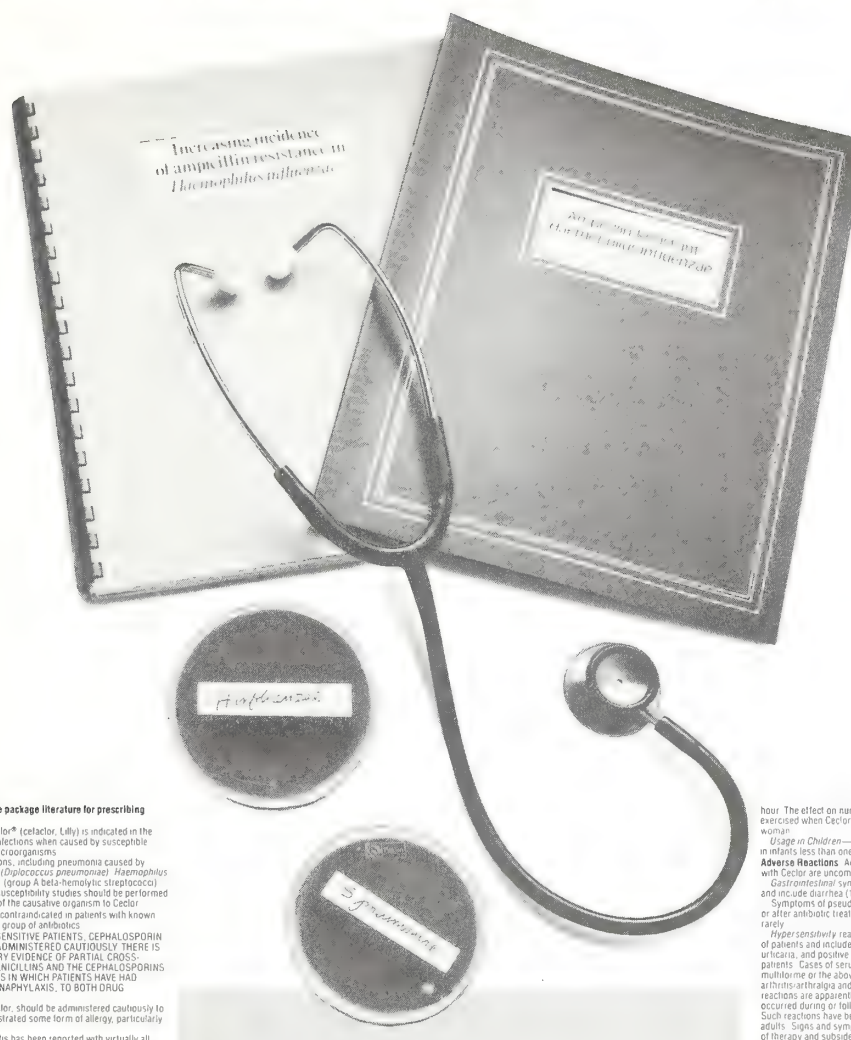
Thousands of Ohioans heard him speak in Cleveland, Columbus, Cincinnati, and Toledo and many more read about his views in their newspapers. Doyle had achieved his goal of communicating his views to thousands of Americans. He returned to England where he continued his work on behalf of spiritualism, while writing an occasional Sherlock Holmes detective story, until his death in 1930.

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13. *Columbus Dispatch*, April 25, 1923, n.p.
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15. *Ibid.*, p 9.
16. Doyle AC: *Our Second American Adventure*. New York, Doran, 1923, p 13.

James G. Ravin, M.D., the Toledo ophthalmologist profiled on this page, is also chairman of the OSMA's Art and Culture Committee.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage Ceflor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (Diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organisms to Ceflor.

Contraindication Ceflor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceflor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics including macrolides, semisynthetic penicillins, and cephalosporins; therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriological studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Ceflor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceflor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hemologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceflor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceflor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinette® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceflor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceflor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceflor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceflor.⁷

hour. The effect on nursing infants is not known. Caution should be exercised when Ceflor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions Adverse effects considered related to therapy with Ceflor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthralgia, arthralgia, and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceflor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome. Cases of anaphylaxis have been reported; half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1-4%).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceflor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Ceflor®

cefaclor

Pulvules®, 250 and 500 mg



Additional information available to the profession on request from:
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Indianapolis, Indiana 46285
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

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Getting Physical

By Gina DiBlasio Cummins

Fifty-year-old Joyce, the top seamstress for a dry-cleaning chain, requires an arm amputation. As she apprehensively awaits the prosthesis, she wonders if her life will ever be the same.

Thirty years ago, the lack of sophisticated treatment and accompanying encouragement may have caused Joyce to become completely disabled and socially withdrawn. Today, new techniques and procedures in the field of physical medicine and rehabilitation have enabled patients such as Joyce, who suffer from a variety of neuro- and musculoskeletal diseases, to have a better chance of psychologically and physically adjusting to their

“The field of physical medicine and rehabilitation has enabled individuals to improve tremendously the quality of their lives.”

impairments. These patients can not only learn to live with their impairments, but live well.

“The field of physical medicine and rehabilitation has enabled individuals



Dr. Wolfe treats a patient with shortwave diathermy, which is a moderate, deep heating modality.

such as stroke victims, amputees and arthritic patients to improve tremendously the quality of their lives,” says Claire Wolfe, M.D., a Columbus physiatrist. She explains that this specialty is responsible for the physical, social, and psychological restoration of those patients whose illness or injury is permanently or temporarily going to change their lives. The main thrust of her practice

is to restore patients to their best productive capabilities.

Restoring these patients to their maximum abilities is a lengthy process and one which sometimes requires this nonoperative specialty to enlist the help of other fields such as neurosurgery, orthopedic surgery and internal medicine. Since a large percentage of the ailments a physiatrist treats are chronic, they

continued on page 437

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The Deaconess Hospital of Cincinnati is pleased to offer a new regional service for patients undergoing total joint replacement. Initiated in November, 1982, by the Hospital in cooperation with its Medical Staff, a comprehensive program has been developed by the orthopedic surgeons of the staff in conjunction with internists, rheumatologists and other support personnel.

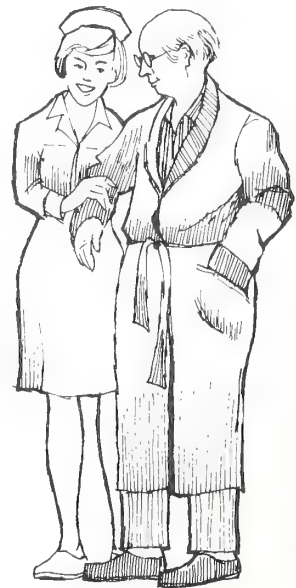
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Any physician can register his patient in the program by contacting The Deaconess Hospital Center for Reconstructive Hip and Knee Surgery.



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Getting Physical

continued

have many repeat patients. "The advantage of seeing the same patients over and over is that we can offer them emotional support and encouragement while simultaneously treating their physical impairments." She explains that the field of physical medicine and rehabilitation is still using the same basic modalities of heat, cold, exercise and massage that have been used for 5,000 years.

"Fortunately, we've significantly improved the procedures and devices which utilize these modalities."

A relatively new instrument, called a TNS (transcutaneous neurostimulator), is used in the rehabilitation of athletes, to treat chronic pain sufferers and stroke rehabilitation patients. About the size of a pacemaker, this device is wired externally to the patient with electrodes through which it electrically stimulates the nerves and muscles.

Many diagnostic advances in this field have been in electrodiagnostic testing. This area, which is becoming increasingly computerized, boasts a variety of electronic devices for diagnostic purposes. One machine which has been updated in recent years is the EMG (electromyogram).

The EMG can produce a graphic record of the electrical activity of a muscle. It can consequently determine the quality of muscle and nerve function.

"The newest and most exciting advance in this area is 'evoked potentials'. In fact, this area of investigation is so new that we're still unaware of its full significance and capabilities." Evoked potentials actually can measure the electrical potential of the brain through visual, spinal cord and auditory stimuli. This technique may be especially useful in locating and determining the severity of impairments such as tumors, spinal cord injuries and multiple sclerosis.

In addition to the advances made in electrodiagnostic testing, Dr. Wolfe notes that progress has touched other areas within physical medicine as well. The most noteworthy improvements which have been made include the following:

- The rehabilitation of amputees

Dr. Wolfe notes that prostheses have become much lighter and more functional for both upper and lower amputees. For upper extremity amputees, work has been done with

myoelectric prostheses. A myoelectric prosthesis is a device which produces an electrical impulse through electrodes attached to the muscles, enabling the mechanical parts, such as the elbow and hand, to function more cosmetically.

- Braces

The very heavy steel and leather braces which individuals such as stroke victims, nerve injury patients and children with cerebral palsy have used in the past have been updated in recent years. These modern braces are made out of plastic — resulting in a lighter, more cosmetic and functional piece of equipment.

The newest and most exciting advance in this area is "evoked potentials" which actually can measure the electrical potential of the brain through visual, spinal cord and auditory stimuli.

- Arthritis, neck and back pain

Physiatrists often work with rheumatologists and other specialists to relieve patients' pain with drug therapy and various physical treatment methods. The use of heat in a technique called diathermy applies heat to the body tissues through a machine which generates an electric current of high frequency. Such heat is capable of deeper penetration into the body to relieve pain. Other devices which utilize heat, such as ultrasound, hot packs and paraffin, also are being used to treat recurring pain, as are exercise programs.

continued on page 439

Dr. Wolfe demonstrates the electromyograph (EMG), used for electrodiagnosis of neuromusculo disease.



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Getting Physical

continued

Dr. Wolfe hopes that future progress made in the field of physical medicine and rehabilitation can keep up with the increasing elderly population. "As a larger percentage of us live longer, more of us will someday suffer from illnesses such as arthritis and stroke.

Physical medicine is still a small specialty which has a great need for more people interested in treating chronic illness.

Physical medicine and rehabilitation is still a small specialty which has a great need for more people interested in treating chronic illness."

In addition to a future need for increased manpower, Dr. Wolfe sees

the future of physical medicine and rehabilitation relying on the increased use of computerization. "This necessary tool has enabled significant advances thus far and will have an ever greater impact on the progress made in the future." She anticipates that perhaps 25 to 30 years from now, computerization will ultimately help spinal cord injury victims and paralyzed patients to walk with little aid.

Since these advances are further down the road, Dr. Wolfe is content to continue doing what she does best — to make these patients as emotionally and physically whole as possible — while teaching them how to optimally live with the impairment with which they have to live.

Gina DiBlasio Cummins is Editor of Synergy and a staff writer for the Ohio State Medical Journal

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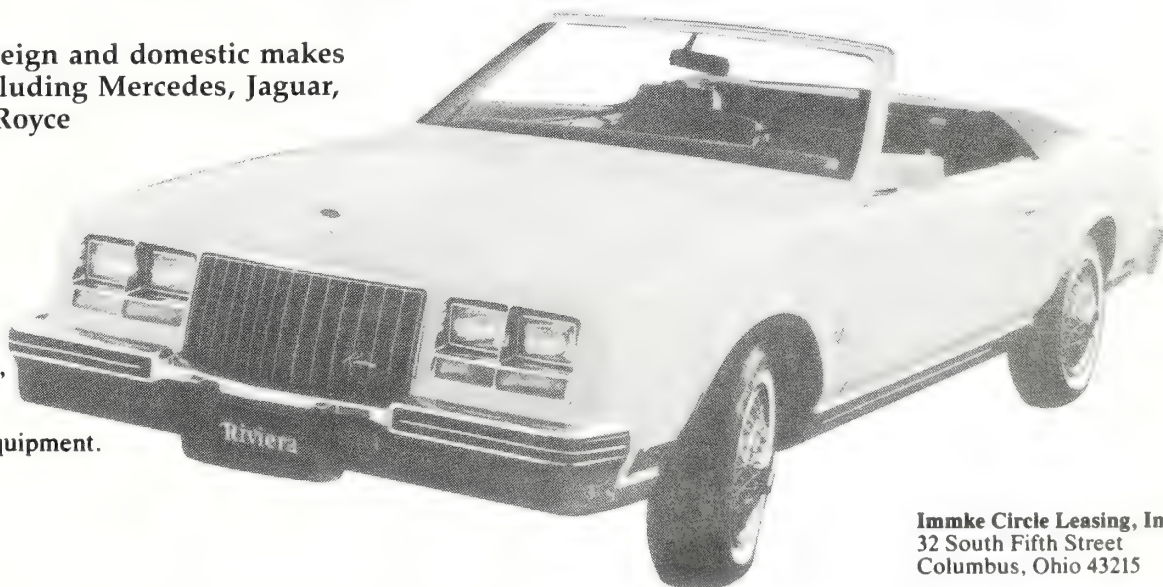
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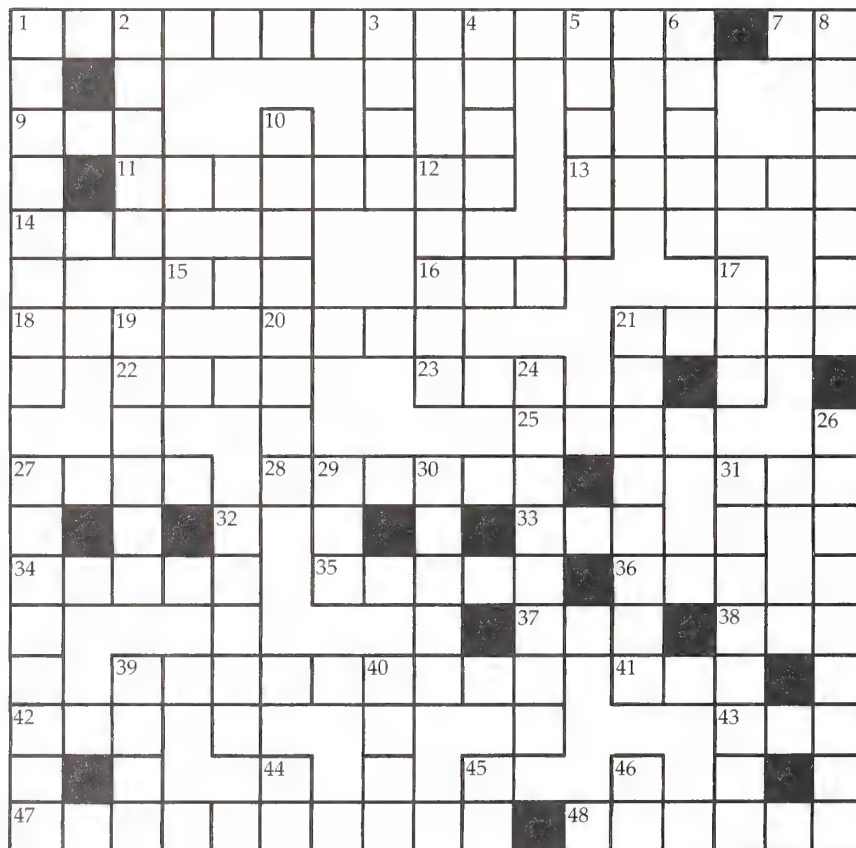
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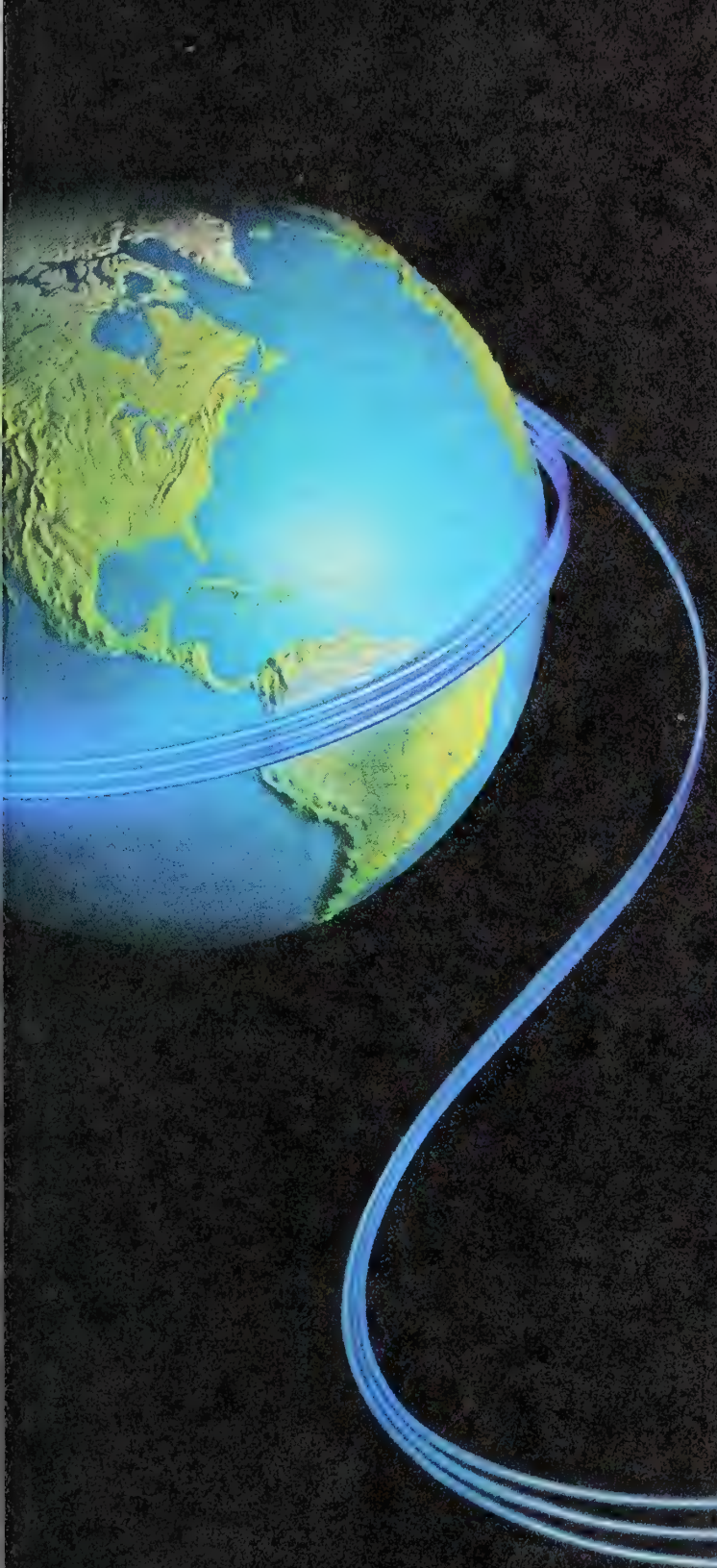
ACROSS: 1. Genetic disease with thick mucus, malabsorption and lung infections, 7. Exist, 9. What's the ____?, 11. Misty method of administering medications in CF, 13. Days of September, April and June, 14. Some like it ____, 15. Food nutrient malabsorbed in untreated CF, 16. Happy ____ Year, 18. Professional basketball league, 20. United States Coast Guard (abbr), 21. Thick material clogging the airways in CF, 22. Chance of recurrence of CF in an affected family: one out of ____, 23. Drink slowly, 25. Curved structure, 27. Sketch, 28. Teaching plan, 31. Recreation wagon, 33. Tin container, 34. Masculine (prefix), 35. Elevated temperature, 36. Follower of (suffix), 37. Large flightless bird, 38. Part of a circle, 39. Lung infection common in CF, 41. Dad's mate, 42. Tint, 43. Three in Rome, 47. Drug used to treat infection, 48. Aunt's child.

DOWN: 1. Reflex induced by postural drainage, 2. Skin test to detect CF, 3. To the inside, 4. Pied Piper followers, 5. Skin taste in patients with CF, 6. Slow moving creature, 8. Medications to aid malabsorption in CF, 10. ____ drainage: method of clearing airways blockage, 12. Respiratory organs often infected in CF, 17. High card, 19. Scared, 21. Impacted dark stool of an infant with CF, 24. Organ affected in CF producing digestive enzymes, 26. Bacterial invasion common in CF, 27. Abnormal bowel movements in CF, 29. Sprite, 30. Lucky number, 31. Dietary supplements A, D, and C, 32. Popular gambling card game, 39. Animal skin, 40. Leave out, 44. Jumbled type, 45. Partner of DC, 46. Therefore.



Solution on page 468

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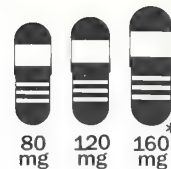
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The appearance of Inderal LA capsules is a trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

COMING SOON

ONCE-DAILY INDERAL[®] LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY

(For full prescribing information, see package circular.)

INDERAL[®] LA brand of PROPRANOLOL HYDROCHLORIDE

(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal LA is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal LA, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

Inderal LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

Inderal LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal LA has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal LA has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal LA also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antiarrhythmic effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal LA is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal LA.

WARNINGS. **CARDIAC FAILURE.** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Inderal (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General. Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Obituaries

HAROLD CRUMLEY, M.D.,
Chillicothe; Hahnemann Medical
College and Hospital, Philadelphia,
1928; age 79; died March 11, 1983;
member OSMa and AMA.

WILLIAM W. FALLER, M.D.,
Cleveland; Hahnemann Medical
College and Hospital, Philadelphia,
1942; age 67; died March 25, 1983;
member OSMa and AMA.

JOHN B. GRAVIS, M.D.,
Springfield; Ohio State University
College of Medicine, 1932; age 82; died
April 26, 1983.

VENCEL JAKAB, M.D., East
Chicago, Illinois; Medical College of
Budapest, Hungary, 1929; age 84; died
March, 1983; member OSMa and
AMA.

HAROLD M. JAMES, M.D.,
Dayton; Ohio State University College
of Medicine, 1927; age 84; died March
23, 1983; member OSMa and AMA.

JOSEPH M. LEVIN, M.D.,
Cincinnati; University of Cincinnati
College of Medicine, 1963; age 46; died
March 1, 1982; member OSMa.

EARL A. ORWIG, M.D., Toledo;
University of Cincinnati College of
Medicine, 1916; age 92; died March 24,
1983; member OSMa and AMA.

SIMON SCHLUETER, M.D.,
Akron; University of Iowa College of
Medicine, 1932; age 84; died March 15,
1983; member OSMa and AMA.

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*Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS. Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1084.
Please see summary of product information on reverse page.

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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage, one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets — bottles of 100



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disorders, the best therapy is
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See important information on next page.

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of pain and anxiety

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Proven superior to aspirin alone in controlled clinical trials

(BRIEF SUMMARY)

DESCRIPTION: Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS: Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e., over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS: ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds. MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g., carisoprodol, meprobamate, or carbromal.

WARNINGS: ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes. MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred.

Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g., anxiety, anorexia, insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinations, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexisting or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease

within next 12-to-48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chloralazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keepa preparations with aspirin out of reach of children. Equagesic-M[®] is not recommended for patients 12 years of age and under. **PRECAUTIONS:** ASPIRIN: Salicylates an-

tagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS: ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. GI: Nausea, vomiting, diarrhea. **CARDIOVASCULAR:** Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption, with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate, meprobamate and meprobamate/car-

bamol. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and

bullous dermatitis have occurred. **HEMATOLOGIC** (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSEAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSEAGE: Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdose produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal.

The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone). Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS: 0.5-2.0 mg percent represents usual blood-level range after therapeutic doses. The level may occasionally be as high as 3.0 mg percent. 3-10 mg percent usually corresponds to

findings of mild-to-moderate symptoms of overdose, such as stupor or light coma. 10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur. At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol). Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration.

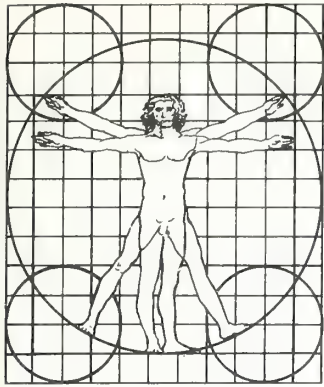
Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED: Bottles of 50 scored tablets.

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CLINICAL & SCIENTIFIC

TUBEROUS SCLEROSIS AND ANGIOMYOLIPOMATOUS KIDNEY CONDITIONS

Paul J. Marsidi, M.D.
Henry A. Wise II, M.D.

A 23-year-old female with end-stage renal failure secondary to tuberous sclerosis had cutaneous, brain, and liver manifestations of the tuberous sclerosis complex. As a recipient, the above individual received a kidney transplant from a cadaveric donor whose autopsy later showed tuberous sclerosis and angiomyolipomas of the kidney. The transplanted kidney was removed nine months postoperatively due to rejection phenomenon. This is the only recorded medical record of transplantation of an angiomyolipomatous kidney to a patient with known tuberous sclerosis and the statistical chances of such an occurrence seem incalculable.

TUBEROUS SCLEROSIS first was described by Bourneville¹ in 1880. Since that time this term has been used to describe patients with the triad of mental retardation, epilepsy, and sebaceous adenomas of the face. Tuberous sclerosis derived its name from the autopsy findings in the brains of afflicted individuals as sclerotic patches, largely composed of neuroglial proliferations, noted on the surface of the cortex as well as within the brain substance.

The disease appears to affect females more frequently than males. Although inheritance occurs through an autosomal dominant gene with incomplete penetrance, about 50% of the cases are the result of new mutations.^{2,3} The basic lesion of tuberous sclerosis is the angiomyolipoma, or hamartoma, that can involve multiple organ systems. These are malformed tissue both of ectodermal origin (brain, skin, retina) and of mesodermal origin (heart, liver and kidneys).⁴

Cerebral lesions are seen as calcium-containing sclerotic nodules and they are located mostly in the area of basal ganglia and the periventricular regions. In 60% to 70% of the cases, skin lesions are present,⁵ the most noticeable being the butterfly distribution of angiofibromas forming the adenoma sebaceum around the nose. Periungual fibromas (Koenen's nodules) are firm, smooth, flesh-colored fibromas arising from the nailfolds. Chagrine's patches are soft, irregularly thickened

plaques usually seen in the lumbosacral region. Retinal phacomias are local proliferations of glial tissue which appear as yellowish areas close to the disc.

Multiple and bilateral renal angiomyolipoma are present in 50% to 80% of patients with tuberous sclerosis,⁶ and these tumors are composed of three substances; smooth muscle, blood vessels, and fat. One of the tissues may predominate to account for the gross appearance of the tumor; however, small foci of the other elements usually are present. Symptoms of renal involvement in patients with tuberous sclerosis may be absent, but, if present, they may have chronic flank pain, an abdominal mass, and hematuria which is attributed to hemorrhage in and around the tumors. Renal failure is considered rare, but when present it is the result of compression of the surrounding tissue by these nodules.⁷ Only seven cases of renal failure secondary to angiomyolipoma have been reported,⁸ and one of these seven underwent bilateral nephrectomy with allotransplantation.⁹ A patient with tuberous sclerosis was observed by the author, and it emphasizes some of the interesting aspects of this disease.

Clinical Observation

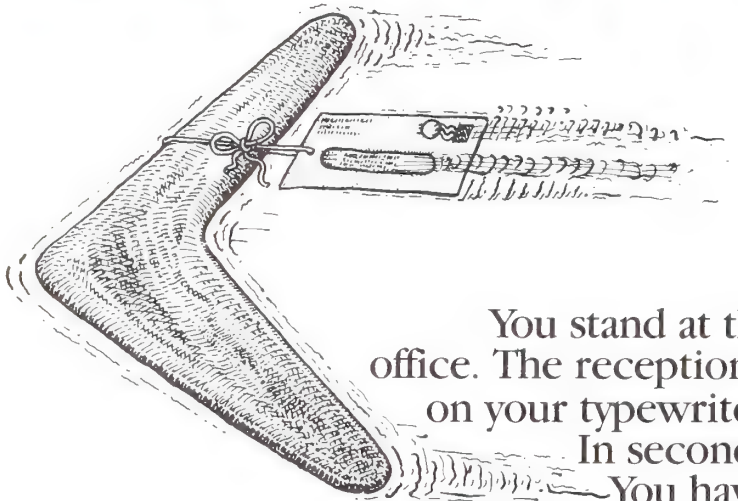
A 23-year-old white female was placed on the waiting list for renal transplantation because of chronic renal failure. The patient had been known for three years to have tuberous sclerosis with skin, bone, brain, liver and renal involvement. Pertinent physical findings were a raised, nonpigmented spot on

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Submitted September 18, 1981.

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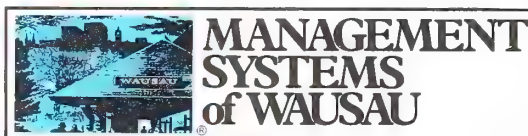
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the skin overlying the third vertebra, a periungual fibroma of the left fifth toenail, and "warts" around her nose.

Although on dilantin and phenobarbital for seizures, she had been an "average" student and was employed as a secretary. Her brain scan and electroencephalogram (EEG) were normal. Skull roentgenograms showed right and left parietal calcifications, and hand films demonstrated lucencies in the proximal and distal phalanges. A renal scan indicated insufficiency with involvement of both glomerular and tubular function. High-infusion nephrotomography outlined kidneys of normal size but with markedly decreased concentration and with no evidence of obstructive uropathy. Angiography studies visualized multiple angiomas and angioliomas in both kidneys and precapillary angiomas in the liver. Microscopic examination of a renal biopsy stained nonspecific fibrosis in the interstitium with periglomerular fibrosis and lobulation consistent with interstitial fibrosis.

A 15-year-old white female was brought to the emergency room after suffering anoxia following a grand mal seizure. She had been institutionalized since childhood because of mental retardation, with an IQ of 35. A carotid angiogram revealed massive hydrocephalus and choroidal and posterior cerebral artery blockage, and an EEG showed no cortical activity. The patient was pronounced dead. The patient's blood urea nitrogen and creatinine were normal, so she became a cadaveric renal donor.

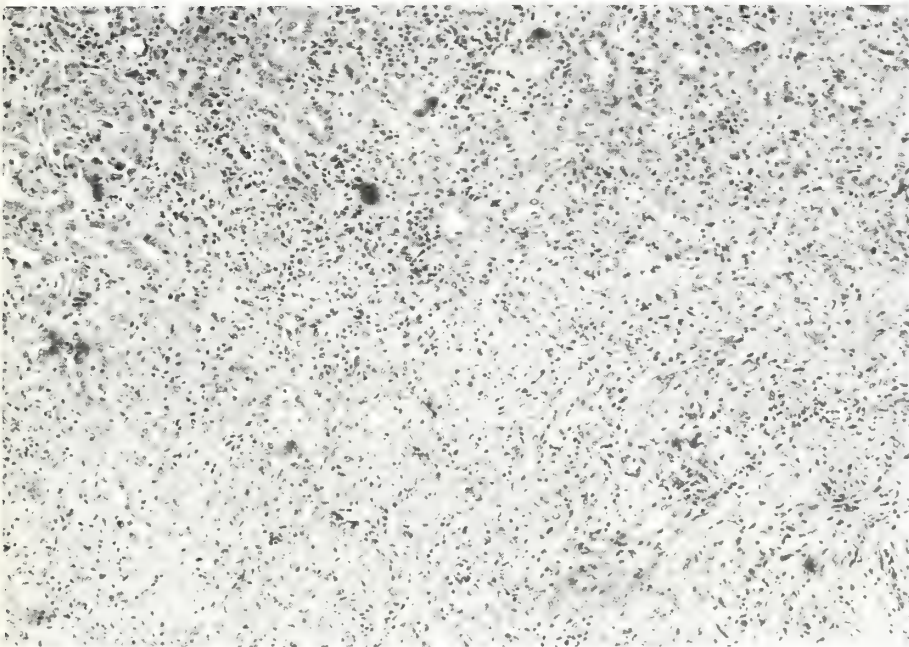
One of the kidneys perfused well on the Belzer apparatus with a flow of 130 cc/min and a pressure of 58/20, so it was transplanted. Small cysts were noted on the surface of both cadaveric kidneys. On the morning after transplantation a microscopic examination of the unused kidney showed proliferated, elongated, smooth muscle cells intermixed with focal

areas of lipomatous tissue and blood vessels. The brain had tuberous sclerosis lesions but the donor had no other manifestation of the tuberous sclerosis complex.

Thirty-six hours after transplantation the recipient's BUN dropped to 21, the creatinine to 1.0. The creatinine clearance on discharge was 70.7 cc/min. Unfortunately, three months postoperatively she began to have a rejection phenomenon and nine months postoperatively a transplant nephrectomy had to be performed. Microscopic examination showed that nearly all arteries were obliterated due to rejection; also, the typical changes of angiomyolipoma were seen: infiltration of mononuclear lymphocytes and few plasma cells, a mixture of polymorphonuclear cells with invasion of the tubules, blood vessels, and glomeruli, pinpoint lumina, intimal edema, and intimal proliferation. Glomeruli were eschismic and showed tuft collapse; marked tubular destruction by invading cells was noted. Immunofluorescence studies showed granular staining for C₃ and IgM in the blood vessel walls and glomeruli showed segmental granular deposits of IgM. Staining for IgG, IgA, C₄ and fibrinogen was negative.

Discussion

For the reader who is statistically inclined, the most fascinating aspect of this clinical observation is consideration of the possibility that a tuberous sclerosis patient with renal manifestations might receive a kidney from a tuberous sclerosis donor who also has renal involvement. Difficulties arise when one tries to estimate the ratio between patients diagnosed with tuberous sclerosis and those who are undiagnosed because of incomplete penetrance (forme fruste), such as was the case of our donor. Problems are compounded when one realizes that



Typical changes of angiomyolipoma: infiltration of mononuclear lymphocytes and proliferated smooth muscle cells, blood vessels and fat cells intermixed.



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our recipient is one of seven reported cases of renal failure in 100 years of literature review for American journals, a time span covering several hundred million population.

Calculations need to begin with the overall incidence of tuberous sclerosis in the literature being 1:100,000 to 1:150,000 in the population at large. The random chances of coincidentally diagnosing two patients with tuberous sclerosis is one in one hundred times ten.⁸

To complicate the computations further, other clinical manifestations need to enter into the calculations. Such considerations as the number of formes frustes of tuberous sclerosis which have not fully developed the diagnostic triad and, therefore, are not included in the overall statistics of the incidence of tuberous sclerosis unless diagnosed at necropsy are not included in the figures of 1:100,000 to 1:150,000 mentioned above. The mutation factor which produces sporadic tuberous sclerosis cases is estimated to be 1:50,000 to 1:120,000, so where is this to be added to the equation? Moreover, our donor had neither the classic adenoma sebaceum manifestation, which is absent only 10% of the time, nor the hereditary factor, so the figures must be reduced by at least a factor of 0.9.

Finally, when considering the chance possibility of these two patients meeting as they did, so to speak, one should consider the incidence of kidney failure among the tuberous sclerosis patients as compared with the general population. Of course, special services of a medical center interested in renal transplantation have a drawing power which increases the possibility of the occurrence, but it is still rare. Applying this to the consideration for renal transplant would be more likely in patients with incomplete neurologic expression of tuberous sclerosis, such as was the involvement of the recipient, rather than in the severely mentally retarded institutionalized donor, and our figures need to be adjusted again. Therefore, this unusual set of events must have a possibility of occurrence in excess of one in several hundred billion. The authors cannot compute this number and would welcome any calculations by the reader.

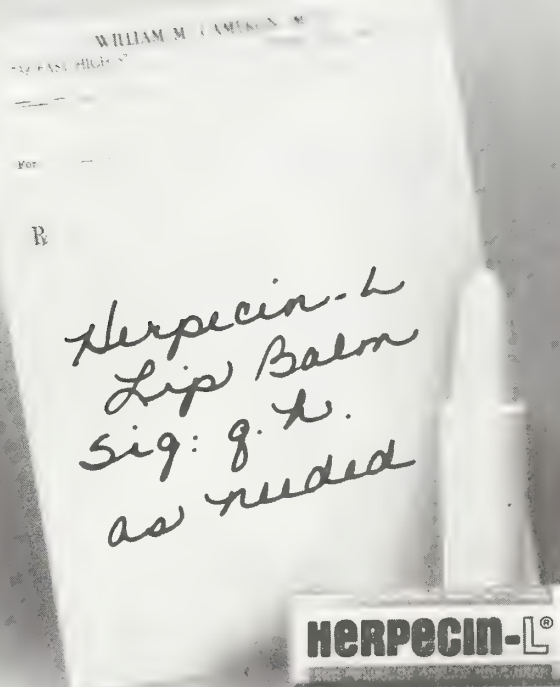
Summary

Tuberous sclerosis is a rare cause of renal failure. Such patients may become eligible for renal transplantation, and the results involving a cadaveric donor transplantation are presented. What makes this a fascinating report is that the recipient inadvertently received a kidney containing angiomyolipomata. The statistical possibilities of this occurring are astronomical, and the authors welcome any help in computing this.

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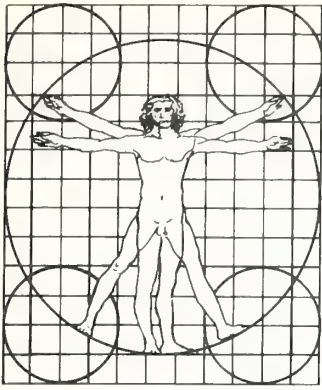
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CLINICAL & SCIENTIFIC

SCABIES: AN UPDATE

Robert C. Rau, M.D.
Richard P. Sturtz, M.D.

Scabies probably represents the most common disease-producing infestation of the human skin in this country. A definitive diagnosis is made by microscopic identification of the mite, its eggs or its feces. Variants of the disease include "scabies incognito," nodular scabies, Norwegian scabies and the canine variety. One percent gamma benzene hexachloride (Kwell) is the most commonly prescribed agent for scabies. Proper management includes concurrent treatment of immediate family members and intimate contacts, and appropriate treatment of antecedent dermatologic disease and the dermatitis which may follow scabies.

A GREAT DEAL HAS BEEN WRITTEN about the epidemic or pandemic of scabies in the 1960s and 1970s. Scabies continues to be a problem in the early 1980s, probably representing the most common disease-producing infestation of the human skin in this country. Many cases are routinely diagnosed and efficiently treated. Other cases, however, are not so easily managed. Hopefully, this brief review will help with some of these "problem cases."

Scabies is an infestation of the stratum corneum by the human itch mite, *Sarcoptes scabiei*, var. *hominis*. The adult female mite is 400 microns, or approximately 1/60 inch long and the adult male is 200 microns long.¹ Transmission of the infestation is presumed to occur when a fertilized female takes to the skin of a new host. The mite scurries across the unsuspecting victim's skin at a rate of 2.5 cm per minute until a proper place to burrow is found.¹ In one hour she has embedded herself in the stratum corneum where she will spend the rest of her days, tunneling at a rate as fast as 5 mm per day, and laying two to three eggs per day.¹ If undisturbed, she may continue this for nearly two months.¹ Unfertilized females and males live in short burrows, and spend much of their time on the skin surface looking for mating opportunities.¹ Immature forms of the mites take temporary refuge in hair follicles.¹

Transmission is most easily accomplished through prolonged intimate contact. Venereal transmission and transmission to family members are common. Fomites are of minor importance in the spread of scabies.¹ Casual contact occasionally may result in infestation and school children often are infested

by their peers. Physicians are also at risk. One of the authors (RCR) has known three physicians who have apparently contracted scabies through a casual dermatologic examination of scabietic patients. Many patients are not aware of when or how they became infested.

The classic presentation of scabies has been well described. Symptoms begin a month or longer after first infestation. Such a delay in the development of symptoms will not be seen with subsequent infestations.¹ The patient experiences itching, often intense, and usually with a nocturnal exacerbation. Papules, burrows, erythema and excoriations are seen. The web spaces of the fingers, the lateral digits and the flexor surface of the wrists are areas commonly involved. The breasts of women and the penis and scrotum of men frequently have typical lesions. The buttocks, thighs, and elbows may be involved. The diagnosis is made by recognizing the typical scabietic burrows and extracting the mite with a needle or by scraping the burrow with a No. 15 surgical blade and examining the epidermal scrapings microscopically. The mature mite, immature forms, feces, eggs, and empty egg shells are all easily identifiable under the microscope (see Figs. 1 and 2).

Problems With Diagnosis

Diagnosis is not always made easily. The key to diagnosis is the scabietic burrow or track. These are most easily found around the hands, in particular the web spaces of the hands, the lateral fingers and the flexor crease of the wrist. Often the burrows are subtle and difficult to find and can only be seen after careful examination with adequate light. Sufficient light may reveal typical burrows in a patient who had appeared normal when examined without this essential aid. The burrows

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Dr. Sturtz, Columbus, Resident in Internal Medicine, Riverside Methodist Hospital.

Submitted December 5, 1981.

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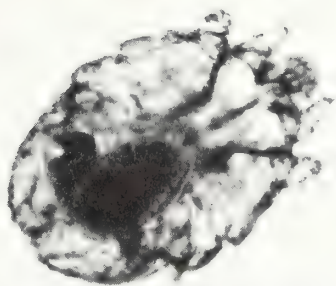


Fig. 1
Mature mite
Magnification — 100X

may be particularly inconspicuous in well-scrubbed individuals. Meticulously clean patients with symptoms suggestive of scabies must be examined with particular care.

To be absolutely certain of your diagnosis, the mite, its eggs, or its feces should be identified microscopically. The simplest technic is to shave off or scrape the burrow with a No. 15 scalpel blade and examine the material microscopically. The most desirable lesion to scrape is the burrow, but if these can't be found, a scraping of a papule will occasionally be positive. If the diagnosis cannot be confirmed on a patient who seems to be a good candidate for the diagnosis of scabies, it may be fruitful to examine family members or intimate contacts in hope of confirming the diagnosis on them. At times it is in the patient's best interest to treat for scabies empirically, despite not having a microscopic confirmation of the diagnosis.

"Scabies Incognito" is the term coined for cases of scabies in which the signs and symptoms of the disease have been masked or altered by the use of corticosteroids.³ Impetigo and eczematoid eruptions frequently complicate scabies and may make the diagnosis less obvious. Scabies may cause antecedent dermatologic disease, such as atopic dermatitis, to flare. One of the authors had a patient with biopsy-proven lichen planus which flared severely after an infestation with scabies. Antecedent and complicating skin diseases must be sorted out to achieve a proper diagnosis and outline proper therapy.

Nodular scabies is a variant of the disease in which pruritic red-brown nodules appear on the genitalia, around the waist, or in the axillary region.³ This form of scabies often persists for weeks after adequate therapy of the scabies infestation. In our experience, the best treatment for these lesions is intralesional corticosteroids.



Fig. 2
Eggs and feces
Magnification — 40X

Norwegian scabies is a rare variant. It is a generalized scaling, crusting eruption with a particular affinity for the hands and feet. It usually is seen in physically debilitated or mentally retarded patients and is quite contagious.³

Sarcoptes scabiei var. *canis* is morphologically identical to the human variety. It causes a very contagious skin disease in canines. The mite can cause dermatitis on human skin, that is pruritic, papular, and at times urticarial. The canine mite does not propagate on human skin and this disease is, therefore, self-limited on humans. As long as the patient has contact with an infested canine, the disease persists. When the infested canine is adequately treated or removed from the patient's environment, the dermatitis clears without further treatment. In these patients, the mite is not demonstrable in skin scrapings and the diagnosis, therefore, is made on clinical grounds.⁴ A similar dermatitis results from exposure to animals infested with cheyletiella species of mites.⁵

Problems With Therapy

Just as underdiagnosis leads to problems in the proper care of this disease, so does overdiagnosis and/or overtreatment. One percent gamma benzene hexachloride is the most commonly prescribed agent for scabies. Reed & Carnrick, the manufacturers of Kwell, the most widely used form of 1% gamma benzene hexachloride, recommend a single application of the cream or lotion to the body from the neck down, to be left in place for 8 to 12 hours. It is quite effective, and usually not associated with side effects, but may be quite irritating to the skin. To avoid unnecessary irritation, treatment obviously should be given only when the diagnosis is confirmed microscopically, or is reasonably certain. The careless or overzealous use of 1% gamma benzene hexachloride may result in significant dermatitis. Preexisting dermatoses may be severely exacerbated by this agent.

Gamma benzene hexachloride is a potent chemical. In different vehicles and higher concentrations it is used as a commercial insecticide. The percutaneous absorption of gamma benzene hexachloride and the toxic systemic effects of the agent have been well documented.⁶ It appears to be potentially toxic to the central nervous system, liver, kidneys, hematopoietic system, and cardiovascular system.⁶ Just how "safe" topical 1% gamma benzene hexachloride is remains controversial, and some experts maintain that when the drug is used properly in patients with no unusual medical or cutaneous problems the risk of toxicity is negligible.⁷ It is our opinion that this drug should not be used in pregnant patients, infants, or any patient with a significantly excoriated or weeping skin. Alternate therapeutic agents include crotamiton and sulfur.⁶

After adequate therapy for scabies, the itching may not stop immediately, but could persist for days or weeks. It is essential that the patient be educated on this point. If this is not understood, the patient may interpret the persistent pruritis as a

sign of therapeutic failure and may continue to apply the antiscabietic agent with a resultant primary irritant dermatitis.

An infested patient may have family members with an asymptomatic infestation. Therefore, the immediate family members of all documented cases should be simultaneously treated with the patient. Intimate contacts outside the immediate family also should be treated. This practice should eliminate the possibility of "ping-pong" reinfestation among intimates. Although the significance of fomites in the transmission of scabies is probably not great,¹ some precautions are in order. Routine laundering of bedding, toweling and clothing should be undertaken simultaneously with treatment.

If the pruritis of scabies, preexisting skin conditions, or the dermatitis which may follow scabies and its proper treatment are not dealt with, the overall therapeutic response will not be good. After therapy with a scabicide, these complicating problems should be treated vigorously. Postscabietic dermatitis or flaring preexisting atopic dermatitis can be just as troublesome as scabies itself. Proper bathing technics, soothing creams or lotions, topical corticosteroids, oral antipruritics, and at times short bursts of oral corticosteroids all may be important in the therapy of postscabietic dermatoses.

Summary

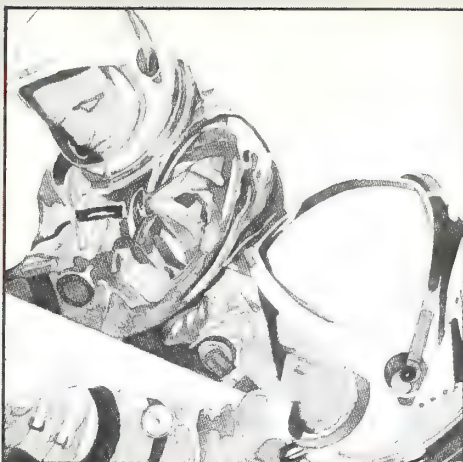
The identification and disposition of infestations with the human itch mite is not always a simple chore. Essential to the proper management of scabies are: (1) careful examination of the patient with adequate light and a microscopically confirmed diagnosis; (2) proper use of an effective scabicide; (3) avoidance of overtreatment; (4) therapy of associated or complicating cutaneous disease; (5) patient education about the disease and course of therapy; (6) awareness of the atypical forms of scabies; and (7) treatment of intimate contacts of the infested patient.

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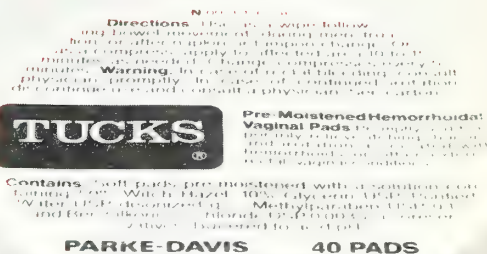
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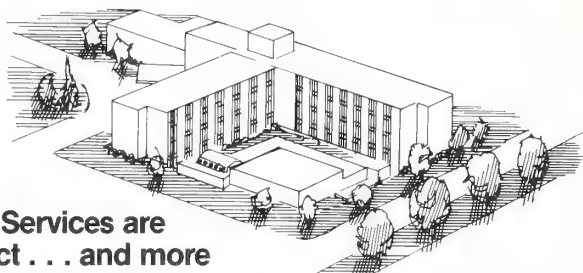
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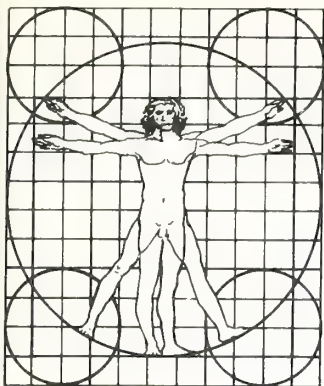
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CLINICAL & SCIENTIFIC

AN EVALUATION OF THE COMBINATION OF MEDICAL AND SURGICAL THERAPY IN THE TREATMENT OF UNSTABLE ANGINA

David M. Sokol, M.D.
George I. Litman, M.D.

Eighty-seven patients underwent surgery for unstable angina after intensive medical therapy failed to resolve the progress of this syndrome. There were no operative deaths. The incidence of perioperative myocardial infarction was 6.6%. There were no other major surgical or medical complications. Follow-up was available on 80 survivors from six months to five years with three late deaths and five late myocardial infarctions. There were no other hospitalizations for cardiac events. Forty-nine percent of the patients are gainfully employed at their usual occupation. Twenty-three patients had been retired prior to surgery. Of the six patients sustaining perioperative infarctions, three (50%) are working full time and are totally angina-free. The average length of stay for all patients undergoing surgery was similar to patients undergoing elective bypass surgery. The intra-aortic balloon pump, although available, was not found necessary in preoperative stabilization.

THE CLINICAL SYNDROME of acute coronary insufficiency, accelerated angina, preinfarction, or unstable angina, remains one in which the optimal therapeutic modality is undecided.¹ The protocol established by the National Cooperative Study Group to compare medical and surgical therapy for this entity is still underway and published reports heretofore² suggest no significant difference between medical and surgical treatment. With the purpose of finding the optimal combination or time sequence in the management of patients with this condition in a community hospital performing open heart surgery, a review was undertaken of all patients undergoing surgical therapy over the past five years. With the therapeutic intention being prevention of death, prevention of myocardial infarction, and the preservation of ischemic myocardium, as well as prolonging useful life and alleviating pain, as stated by Conti,³ an attempt was made to treat these patients in a unified manner, without controls, but using the definition of the preinfarction syndrome.

Methods

For purposes of the study the definition of the National Cooperative Study Group of Unstable Angina was used.¹ This

includes a changing clinical pattern of angina consisting of either a new onset angina at rest or on effort, an increase in severity, frequency, or duration of anginal episodes, and clinical presentation requiring admission to a coronary care unit for evaluation. There was no arbitrary age limit, but patients sustaining a myocardial infarction within the previous three months have been excluded, as per criteria of the Cooperative Study. The electrocardiograms were examined and for inclusion and definition in this study, all patients had pain associated with transient S-T or T wave changes, or both, that reverted to normal within 24 hours. In addition, the serum isoenzymes, including SGOT, CPK, and LDH values ruling out infarction, were necessary for inclusion in this study. Likewise excluded were patients with new pathological Q waves.

Patients were admitted to the coronary care unit and all attempts were made at stabilization prior to study. Optimal medical therapy included the use of bed rest, sedation, oxygen, analgesia including opiates, beta blocking agents and coronary vasodilators (nitrates). No patients were taken to surgery directly unless at least a 12-hour period of attempts at medical stabilization had been undertaken. If the above therapeutic interventions were unable to control the pain, cardiac catheterization and angiography were performed. Though available, the intra-aortic balloon pump was not used to either decrease pain or reverse electrocardiographic changes.

Surgery was undertaken in all cases, using cardiopulmonary bypass with hemodilution and systemic as well as cardioplegic hypothermia. All major diseased vessels with adequate lumens were bypassed. Postoperatively, all patients were monitored for 48 hours in an intensive care setting and determination of serial isoenzymes (CPK and LDH) were done at 12 hourly intervals with electrocardiograms being done on at least a daily basis. Following surgical recovery the patients were returned to their general hospital floor and discharged within the usual time period for elective bypass surgery.

Dr. Sokol, Akron, Chief of Cardiac Surgery, Akron General Medical Center.

Dr. Litman, Chief of Cardiology, Akron General Medical Center.

Submitted October 22, 1981.

Follow-up catheterization was done only where recurring or persistent angina followed the normal postop recovery. Follow-up for patient status was determined by questionnaire which asked for the presence or absence of subsequent hospitalization for a coronary event, presence or absence of angina since surgery, and if so, whether greater or less than prior to, and employment status including the same or a less active occupation. If retired, they were asked whether retirement was due to medical or economic reasons and if medical, could they have worked at a less strenuous occupation. Included was a question of current medication and a patient's estimate of the level of activity tolerated in their free time and a comparison of this status as related to that prior to surgery. The results were as follows:

A total of 87 patients fit the criteria for inclusion in this study and underwent surgical therapy; there were 63 males and 24 females. 35% of the group had essential hypertension and 22% had diabetes mellitus. Five patients had both hypertension and diabetes. Fifteen of the patients were determined at the time of either catheterization or electrocardiogram to have had previous myocardial infarction without known clinical presentation. The median age of all patients was 57 years. The average time between catheterization and surgery was 3.7 days with 11 patients undergoing surgery on the same day as catheterization, 41 patients within two to five days of catheterization, 22 between the sixth and tenth postcatheterization day, three between 11 and 14 days, 8 between 15 days and two months, and in two the time between catheterization and surgery was unknown, as this procedure had been done in the remote past. Though catheterization was done early in the acute course, medical treatment was continued in some cases up to two weeks if progress was being made in controlling both the symptoms and electrocardiographic changes. Surgery was undertaken either upon no progress being made or worsening of symptoms after an initial period of improvement. There was a total of 201 saphenous vein grafts performed on these 87 patients, for an average of 2.3 grafts per patient. There were no operative deaths. Six patients (6.6%) sustained perioperative myocardial infarction as determined by new Q waves or significant enzyme elevations. There were no other significant medical or surgical complications in the remaining 81 patients. In the remaining follow-up time which ranged from four months

to five years, five patients sustained a late myocardial infarction (5.8%). There were three late deaths in the follow-up period (3.4%). One patient expired at three months and another at 20 months following surgery. These were sudden, unexpected, and presumably coronary deaths, but all occurred outside of the hospital and no autopsy was available. The third patient died one year and five months after surgery as a result of metastatic hepatic carcinoma. At the time of his demise he had no cardiac symptoms.

For purposes of postoperative evaluation, only patients having less than complete relief of angina underwent recatheterization and this group totaled 16 patients. Of the total of 36 grafts performed in these patients, 25 (70%) were patent. Only one patient had no patent grafts. Patients with no or minimal signs or symptoms were not restudied. Of the remaining long-term survivors available for follow-up (80%), 47 are totally angina-free and completely asymptomatic. Twenty patients have mild angina but definitely less than that noted prior to surgery and have not had a readmission for a coronary event in the follow-up period. Nine patients report similar angina to that experienced before the acceleration which prompted their acute admission and surgery. Three patients report angina worse than before acceleration. Twenty-nine patients are totally without any need for medication. Regarding the activity status, 39 patients, or 49%, are gainfully employed. Twenty-three are or have been retired. Thus, a total of 67 patients, or 83%, have not had occasion for a late coronary-related hospitalization and have sustained a complete or significant relief of symptoms without progression of angina or a late myocardial infarction. The period of follow-up is too short and the number of patients too small for a claim of increased longevity. Of the six patients who sustained perioperative myocardial infarction, three, or 50%, are working full time and totally angina-free. One patient took a medical retirement, one patient is not working but had been previously retired prior to his surgery, and one patient expired three months postoperatively (see Table 1).

Discussion

The number of patients responding to medical therapy and, therefore, not requiring surgery during this same time period,

TABLE 1
SUMMARY OF PATIENTS STUDIED

TOTAL NUMBER PATIENTS STUDIED	87	
HOSPITAL SURVIVORS	86	
LATE DEATHS	3	
LOST TO FOLLOW-UP STUDY	3	
LENGTH OF STAY IN HOSPITAL (POSTOP)		
(80) PATIENTS WITH UNEVENTFUL COURSE	10	DAYS
(6) PATIENTS WITH MI	12	DAYS
ACTIVITY STATUS IN FOLLOW-UP		
RETURNED TO WORK	39	(47.5%)
PREVIOUSLY RETIRED BUT ABLE TO DO ALL ACTIVITIES ...	23	(28.2%)
RETIRED FOR MEDICAL REASONS	17	(21.2%)
SUBSEQUENT HOSPITALIZATION FOR MI		
RETURNED TO WORK	2	
MEDICALLY RETIRED	3	

TABLE 2
TREATMENT COMPARISON
UNSTABLE ANGINA

	MORTALITY		MI	
Natural History Study (Gases)				
Medical Rx	43	%		
Cooperative Study				
Medical Rx	9	%		
Surgical Rx	10	%	17	%
Collected Results (Conti)				
Medical Rx	6.2%		7.8%	
Surgical Rx	6.3%		9.6%	
Operations Within 24 Hours				
(Cleveland Clinic)	4	%	18	%
“Combined Treatment” (AGMC)				
Medical with Surgical	1.1%		6.6%	

is not available for inclusion in this study. With a low in-hospital operative mortality and myocardial infarction rate, as well as an excellent intermediate term follow-up with a minimal recurrence of acute coronary events and overall long-term survival of 96%, we feel this approach allows utilization of the best of both worlds in terms of management and intervention. We would agree with the conclusions of Golding, et al,⁴ that though the risk of preoperative loss of myocardium exists by waiting, a period of observation and stabilization, with the ability to intercede if the situation worsens, should decrease both the operative mortality and the perioperative infarction rate. In this situation we have not found it necessary to utilize the intra-aortic balloon pump for stabilization of either pain or electrocardiographic changes, preferring to proceed with surgery and use the balloon pump only if necessary in weaning from cardiopulmonary bypass.

Despite, or perhaps because of, the failure of the National Cooperative Study to demonstrate a superiority of one form of therapy over another in managing the clinical syndrome of unstable angina, and accepting the absence of a control group and a prospective study, we nevertheless feel the results of this review suggest several conclusions. The first and perhaps the most significant is that the question should better be placed, rather than medicine versus surgery, the timing of surgery in an overall medical context. While recognizing the inherent limitations in comparing data bases between collected series, it nevertheless is helpful to review the excellent collection of data presented by Conti, et al.⁵ In a review article encompassing over two dozen series, both medical and surgical therapy, the results of 558 patients treated medically revealed a 6.2% death rate and a 7.8% myocardial infarction rate. Complications, which were not defined, are listed as 14%. A collection of 1,392 reported surgical cases revealed an operative mortality of 6.3% and myocardial infarction rate of 9.6%, with again the 15.9% complication rate. Gazes⁶ in a review of a ten-year follow-up of a prospective study of 140 patients with unstable angina, found that in the high risk subgroup (54), the cumulative survival rate was 57% at 12 months and only 37% at 60 months. In this group, 35% of patients developed a myocardial infarction within three months of the onset of their unstable angina and of these, 63% expired. Bertolasi⁷ in 1976 reported a 46% mortality after 32 months in the medically treated group and an incidence of myocardial infarction of 38%. Unfortunately, in that series the surgically treated group showed no significant improvement. Likewise, the acutely operated series from the Cleveland Clinic⁵ showed an operative mortality rate of 4%

with an 18% incidence of perioperative myocardial infarction (see Table 2).

We have chosen to address the issue from the point of view of first attempting medical stabilization and, if this is unsuccessful within a 12-hour period, proceeding with catheterization. Should medical stabilization be successful the patients would be studied electively or upon worsening of the symptoms. Because of the significant number of patients undergoing surgery beyond several days of catheterization, that is, 35 having their surgery greater than five days after catheterization, these patients might be considered analogous to that of the controlled "cross-over" group.

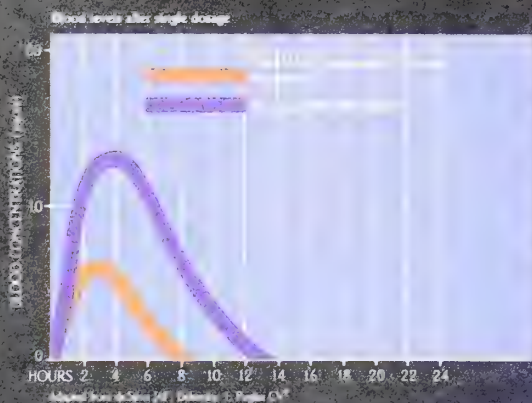
It should be noted that 11 patients underwent surgery on the same day as catheterization and 41 within two to five days thereafter.

With the constantly changing clinical and electrocardiographic changes attendant upon this syndrome and the unpredictability of each course, as well as the situation in which patients with acute unstable angina usually present to their nearest hospital, consideration should be given to the validity of such primary care centers where surgery can be performed with acceptable results of being perhaps a more appropriate setting for the treatment of this syndrome.

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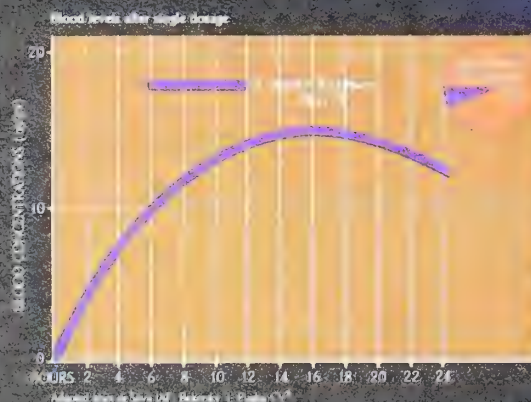
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A metabolite that accounts for only 4% to 7% of dose in plasma

Another metabolite of Dalmane— N_1 -desalkyl-flurazepam—has a serum half-life of 47 to 100 hours.² This metabolite accounts for only 4% to 7% of an average dose measured in plasma.¹ It accumulates to steady state within 7 to 10 days,² and disappears gradually after discontinuation of therapy.

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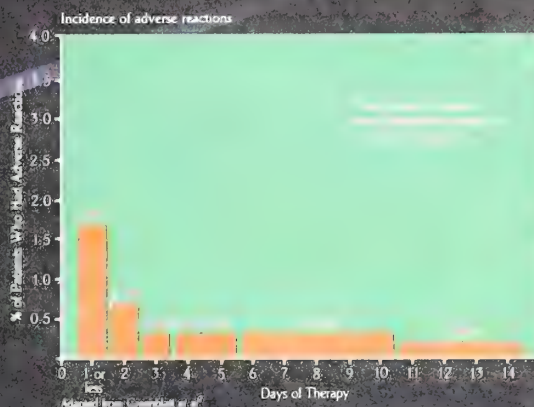
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Contemporary Hypnotic Therapy **83**



No rebound insomnia for up to two weeks

Rebound insomnia has been reported as a potential clinical problem on the first nights following withdrawal of certain benzodiazepine hypnotics.^{5,8} Yet with Dalmane there have been no reports of rebound insomnia for up to two weeks. In eight of eight sleep laboratory studies, patients showed no evidence of rebound insomnia on the first nights after Dalmane therapy was discontinued.⁹ Even on nights 12 to 14 following discontinuation of Dalmane, rebound insomnia had still not occurred in one study.⁴

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. deSilva JAF, Bekersky I, Puglisi CV: *J Pharm Sci* 63:1837-1841, Dec 1974. 3. Kaplan SA et al: *J Pharm Sci* 62:1932-1935, Dec 1973. 4. Kales A et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 5. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977, and Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Sommerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 7. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 8. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 9. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981.



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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

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12. **EDITORIAL ASSISTANCE.** Ms. Carol J. Wiley, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

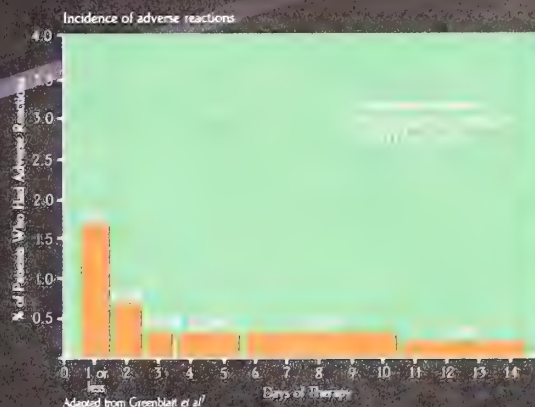
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Contemporary Hypnotic Therapy **83**



No rebound insomnia for up to two weeks

Rebound insomnia has been reported as a potential clinical problem on the first nights following withdrawal of certain benzodiazepine hypnotics.^{5,8} Yet with Dalmane there have been no reports of rebound insomnia for up to two weeks. In eight of eight sleep laboratory studies, patients showed no evidence of rebound insomnia on the first nights after Dalmane therapy was discontinued.⁹ Even on nights 12 to 14 following discontinuation of Dalmane, rebound insomnia had still not occurred in one study.⁴

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. deSilva JAF, Bekersky I, Puglisi CV: *J Pharm Sci* 63:1837-1841, Dec 1974. 3. Kaplan SA et al: *J Pharm Sci* 62:1932-1935, Dec 1973. 4. Kales A et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 5. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977; and Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 7. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 8. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981.



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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

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S. Baird Pfahl, M.D.

New Involvements

By S. Baird Pfahl, M.D.

Our annual OSMA meeting is over and my year as your president has started. The honor you have bestowed upon me will not be taken lightly. Leaders are often asked, "Why do you get involved?" I can't answer for others, but to me the challenge of new and different horizons or goals as well as the excitement of interacting with many different types of people, are the reasons why I became "involved."

As we look ahead, the usual "problems" still confront us, ie, legislative activity by nonmedical practitioners and regulatory agency

to consider the quality of medical care given to these patients (I don't like the word recipient - nor for that matter - vendor) when evaluating the system or systems placed before you.

A new direction for your state society will be the formation of a committee to evaluate the medical as well as socioeconomic problems of that rapidly growing segment of our population - the elderly (growing by 2% per year). The committee, chaired by Marshall R. Werner, M.D., Akron, will be asked to correlate medical information from the many specialties

As we look ahead, the usual "problems" still confront us, i.e., legislative activity by non-medical practitioners and regulatory agency rules, often formulated without consideration of medical issues.

rules, often formulated without consideration of medical issues. Medical care costs continue to rise and have fostered increased activities in alternative health care delivery systems, including the old names — HMOs, IPAs and now adding the new PPOs and "gatekeeper" systems.

Your society will keep you informed of these fast moving areas so you may decide their merits or demerits in light of your individual situation.

Medicaid may be revamped by the time you read this, and I ask all of you

involved and keep our membership informed and educated. The costs of institutional care for the elderly are frightening and we need to evaluate alternative kinds of care, ie, daycare, community resources, "sitters," etc. Our talented Auxiliary may be able to help evaluate these aspects and together, I am sure, we can make a difference.

It is an honor to serve as your president and please let us know how your organization may serve you better. **OSMA**



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Letters ...to the editor

Family caretakers and the elderly

To the Editor:

I would like to clarify a point made in the May 1983 issue of the *Ohio State Medical Journal* in the article entitled "Home Crowded Home." In the article, I was quoted as saying "A number of older people are placed into homes because they are incompetent or incontinent and their relatives don't want to deal with it anymore." The situation is generally not that relatives don't want to deal with these problems, but that they can't deal with the stress of giving care to an aged relative. These stresses become particularly acute when the disabled person can no longer be left alone out of fear of danger to herself or the household, or when they lose bowel and bladder control. With family

members frequently suffering guilt feelings when placing a relative in a nursing home, it is important for us to recognize the difficulties family caretakers experience when facing this dilemma. Thank you for allowing me to correct this misperception.

Sincerely,

/s/Jayne Moser

State Nursing Home Ombudsman
Ohio Commission on Aging

(The OSMA Journal welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.)

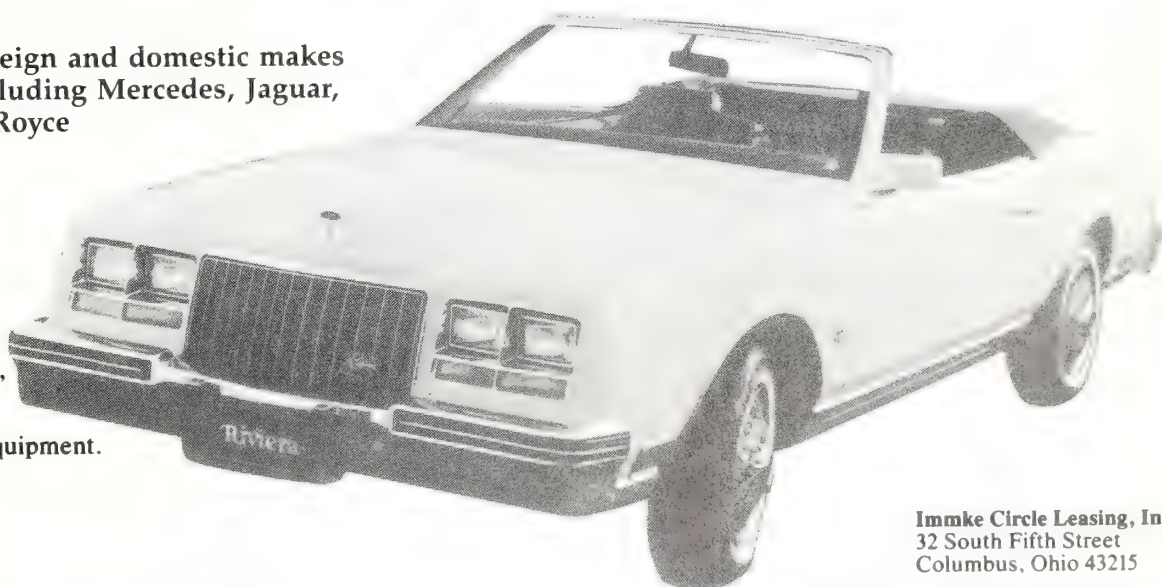
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J. JAMES ANDERSON, M.D., Youngstown, was elected president of the Youngstown Hospital Association. **CHARLES H. MCGOWEN, M.D.**, Poland, was elected president-elect and **THOMAS BARRETT, M.D.**, Youngstown was elected secretary-treasurer.

Appointed to the Board of Trustees of the OSMA Education and Research Foundation were: **OSCAR W. CLARKE, M.D.**, Gallipolis, chairman, **HERMAN I. ABROMOWITZ, M.D.**, Dayton, **PERRY R. AYRES, M.D.**, Columbus, **MRS. ROSE VESPER**, New Richmond, past president OSMA Auxiliary, and **MR. HART F. PAGE, CAE**, executive director of the OSMA.

STEWART B. DUNSKER, M.D., Cincinnati, was recently installed as President of the Ohio State Neurological Society. Dr. Dunsker is a past president of the Ohio State Medical Association.

JOHN J. GAUGHAN, M.D., Cleveland, was elected chairman of the board of Physicians Insurance Company of Ohio. Dr. Gaughan, a radiologist, has served on the board since 1976. He was also the former board chairman for PICO's subsidiary, the Professionals Insurance Company.

WILMER G. HECETA, M.D., Bellaire, Ohio, is the new Chief of Staff for Bellaire City Hospital for the term 1983-1985. He is also Chairman of the Hospital's Utilization Review Committee and is Medical Director of the Bellaire Medical Group, Bellaire, Ohio.

JOHN C. KELLEHER, M.D., Toledo, has been elected Vice President of the American Association of Plastic Surgeons at their recent meeting in Boston, Massachusetts. The American Association of Plastic Surgeons is devoted to reviewing and encouraging the educational practices in plastic and reconstructive surgery.

KONRAD F. KIRCHER, M.D., Dayton, was recently elected president of the Ohio State Radiological Society. Other officers include: **LAWRENCE G. THORLEY, M.D.**, Amherst, president-elect; **JAMES D. CURRY, M.D.**, Mansfield, treasurer; **CHARLES F. MUELLER, M.D.**, Columbus, secretary; and **CHARLES M. KLEIN, M.D.**, Toledo, immediate past president.

JORGE MEDINA, M.D., Cleveland was elected president of the International College of Surgeons. Dr. Medina's specialty is thoracic surgery.

S. THEODORE PINSKY, M.D., Toledo, is the recipient of the 1983 Ohio State Radiological Society's Distinguished Service Award. Dr. Pinsky, who is a past president of the Society and is currently a Councilor to the American College of Radiology, was honored at the 43rd Annual Meeting of the OSRS for his service and dedication to the field of Radiology.

Dr. Pinsky also has been active in various capacities in the Ohio State Medical Association and the Academy of Medicine of Toledo and Lucas County and is a member of the



Stewart B. Dunsker, M.D., Cincinnati, President of the Ohio State Neurological Society



John J. Gaughan, M.D., Cleveland . . . PICO's new Chairman of the Board



Wilmer C. Heceta, M.D., Bellair . . . Chief of Staff for Bellaire City Hospital

continued on page 479

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahiolu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Colleagues in the News

continued

American Medical Association. He has served in the past as an Alternate Delegate to the OSMA House of Delegates from Lucas County and was recently chosen to serve as the Delegate to OSMA from the Ohio State Radiological Society.

A. BURTON PAYNE, M.D., Ironton, was elected chairman of the board of the Professionals Insurance Company, a subsidiary of the Physicians Insurance Company of Ohio. Dr. Payne, an anesthesiologist, has served on the company's board since 1980, and was the former board chairman for PICO's other major subsidiary, PICO Life Insurance Company, now American Physicians Life Insurance Company.

OSCAR D. RATNOFF, M.D., Cleveland, was recognized for his outstanding contributions to medicine by the American College of Physicians (ACP) in San Francisco. Dr. Ratnoff and twelve other physicians were honored with ACP Mastership during the evening awards ceremony of the ACP's four-day scientific meeting.

HELMUT SCHREIBER, M.D., has been elected to the Board of Directors of the Academy of Medicine of Cleveland. Dr. Schreiber is chairman of the Department of Surgery at Huron Road Hospital and is currently an assistant clinical professor of surgery at Case Western Reserve University School of Medicine. He is a member of numerous professional organizations in addition to the Academy of Medicine, including the American College of Surgeons, the American Federation for Clinical Research and the Ohio State Medical Association.

ROBERT J. WHITE, M.D., Ph.D., Cleveland, was presented the "Neurosurgeon of the Year" award at the Ohio State Medical Association's Annual Meeting, May 16. The Ohio State Neurosurgical Society presented the award to Dr. White.



John J. Kelleher, M.D., Toledo . . . new Vice President of the American Association of Plastic Surgeons



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Slow brain stem growth may induce sudden infant death symptoms

Slow growing brain stem cells may induce sudden infant death syndrome (SIDS) characteristics, say Ohio State University college researchers.

"Clinical observations of SIDS and near-miss SIDS infants have implicated a respiratory control dysfunction," says Nobuhisa Baba, M.D., and colleagues in a recent issue of the *Journal of the American Medical Association*. "It is believed that the maturational state of the neurons in the brain stem may be of major importance in the multifactorial pathogenesis of SIDS."

The researchers postulate that nerve network (dendrite) abnormalities, observed in the brain stems of SIDS victims, could be responsible for imbalances in electrical messages to the lungs and related structures.

Ribavirin promises greater relief

A new aerosol applied antiviral agent, ribavirin, reduces common cold discomfort, and halves the communicability potential and fever duration among influenza sufferers, reported researchers in a recent issue of the *Journal of the American Medical Association*.

The ribavirin studies show it has great potential as a remedy for influenza A and B and respiratory syncytial virus (RSV), comments University of Virginia's David S. Fedson, M.D., in an accompanying editorial.

"Ribavirin aerosol therapy promises to be far more important in the treatment of infants, young children and older adults who are hospitalized with serious illnesses," says the physician. "It is important to reemphasize that the major promise of ribavirin aerosol therapy lies in its broad spectrum of antiviral activity."

One of the ribavirin studies, conducted by Harvey W. McClung, M.D., and associates at Baylor College of Medicine, Houston, shows that the aerosol application proves more effective than oral administration because the latter technique delays drug delivery to the infected site.

"We know of no previous report of the successful treatment of influenza B virus infection in man," say the researchers. "With this development, the treatment of influenza is simplified because treatment can be started immediately with the awareness that therapy effective against both A and B virus infections is being used."

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Gina DiBlasio Cummins

AIDS — The theories continue

Evidence suggesting that acquired immune deficiency syndrome (AIDS) can be transmitted by routine household contact is discussed in a recent issue of the *Journal of the American Medical Association*.

James Oleske, M.D., MPH, and colleagues report eight cases of otherwise unexplained immune deficiency syndrome among children from the Newark, N.J., metropolitan area born into families with recognized risks for AIDS.

"Our experience suggests that children living in high-risk households are susceptible to AIDS and that sexual contact, drug abuse or exposure to blood products is not necessary for disease transmission."

Related articles by Arye Rubinstein, M.D., and others, and Joseph Sonnabend, M.B., MRCP, and colleagues suggest that AIDS can be transmitted to fetuses in the mother's womb, and that the syndrome is acquired by male homosexuals as a result of lifestyle behavior that apparently overworks and ultimately virtually destroys the immune system.



All infants exhibit some form of breathing cessation, called apnea, during sleep, but near-miss SIDS patients (those infants revived before suffocation) exhibit much longer breathing pauses that may indicate slower brain development, comment the researchers.

Baba notes that this maturity lag may induce abnormal sleep patterns that cause failure to arouse from sleep during a critical respiration pause.

"It also has been suggested that infants may be at risk for prolonged apnea if their arousal response is impaired during sleep. An upper respiratory tract infection, which is associated with sleep deprivation, restlessness, and irritability, may play a role in depressing the arousal mechanism in the brain stem," say the researchers.

AMA sets patient examination guidelines

Healthy young adults should have medical examinations once every five years; youngsters every year or two; and people in their prime (40 to 65 years old) at one- to three-year intervals, according to American Medical Association guidelines published in a recent issue of the *Journal of the American Medical Association*.



At the foundation of the AMA guidelines is the belief that periodic medical evaluation of healthy individuals is important for the early detection of disease, particularly such treatable conditions as amblyopia (dimness of vision), diabetes mellitus, cervical cancer, hypertension and glaucoma. With regular surveillance, a

physician also can recognize the development of risk factors for disease and intervene with counseling and treatment.

The frequency of these examinations and the procedure to be performed will vary with the patient's age, socioeconomic status, heredity and other individual factors, according to the Council on Scientific Affairs report.

Certain groups of healthy persons, because of genetic, occupational or socioeconomic factors, will require more intensive diagnostic testing and surveillance than other persons, the Council says. Such persons might be, for example, workers with prolonged exposure to toxic chemicals or to ionizing radiation, an infant whose mother may have had an acute viral infection early in pregnancy, or a middle-aged man with borderline high blood pressure.

The AMA further recommends that physicians should improve their skills in dealing with lifestyle problems such as hypertension, obesity, anxiety and depression, as well as the excessive use of alcohol, tobacco and drugs. "One of the greatest benefits of the patient's periodic visits to the physician," the Council report points out, "is that both patient and

physician have the opportunity to build the mutual trust and knowledge that will stand them in good stead, not only when acute illness may require the physician's care, but also when the physician attempts to foster those behaviors and activities that contribute to the prolonging of the patient's healthful and productive life."

PICO increases excess liability coverage limits

Effective July 1, 1983, PICO will increase its excess medical professional liability coverage limits by \$200,000 at no additional premium charge.

This new program of excess coverage is extremely appropriate in the current high-risk liability environment. Many physicians have contacted PICO and its agencies in recent months to discuss increasing their present limits of coverage. The added \$200,000 limits of protection will provide the extra security many present and prospective policyholders are seeking.

All existing PICO excess policyholders will be contacted this month with further information about the increased limits and with endorsements to their present policies.

In effect, a policyholder who formerly carried \$200,000/\$600,000 primary coverage with \$1 million excess (\$1.2 million/\$1.6 million total coverage limits) will now carry \$200,000/\$600,000 primary with \$1.2 million excess (\$1.4 million/\$1.8 million total limits). Policyholders with \$100,000/\$300,000 primary coverage and \$1 million excess will now have \$1.3 million/\$1.5 million total protection. Additional layers of excess coverage may be carried over the above limits in increments of \$1 million as before.

For more information, physicians should contact their local PICO agents, or call the Customer Service Department at PICO, toll free in Ohio, 1-800-282-7515.

"Natural" foods linked to toxic side effects

"Natural" foods and herbal medicines have become popular in the United States during the past two decades, and consumers often assume that these products are free of toxic side effects. But that's not always the case, according to an Indianapolis physician writing in a recent issue of the *Journal of the American Medical Association*.

Redmond P. Hogan III, M.D., from the Indiana University Medical Center, reports that a female patient who was in the habit of drinking prodigious quantities of a home brewed herbal tea suffered episodes of abnormal menstrual bleeding. Dr. Hogan found that her problem was caused not by a

gynecologic disorder but by natural anticoagulants in the tea.

The woman's recipe included ground tonka beans, melilot (sweet clover) and the herb sweet woodruff, all of which are used in the pharmaceutical industry as sources of coumarin, a potent blood-clotting inhibitor. She had consumed 20 pots of the tea in a two-week period to stave off hunger pangs while dieting. In addition, she had been taking other drugs that either increased the effects of coumarin or themselves served to inhibit blood clotting. The patient's bleeding problem stopped after she ceased drinking the tea and taking the other medications.

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- How to communicate preventive collection policies which increase income.
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- How to introduce and use a PAYMENT AT THE TIME OF SERVICE collection policy.
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- How to use the telephone to obtain patient compliance regarding delinquent accounts.
- How to develop an insurance follow-up system.
- How to keep the legal and ethical considerations of the collection process in perspective.

The Faculty

Both workshops will be conducted by professionals on the staff of the AMA Department of Practice Management. All are experienced educators in medical practice management and conduct educational programs nationwide for physicians, office managers, and medical assistants. An income tax deduction may be allowed for educational expenses undertaken to maintain or improve professional skills. See Treasury REGULATION, 1.162-5.

Registration Form

MEDICAL MARKETING STRATEGIES WORKSHOP

- ☐ Tuesday, September 20, 1983 ☐ Friday, September 23, 1983
 Ramada Inn ☐ Holiday Inn - Independence
 2340 S. Reynolds Road ☐ 6001 Rockside Road
 Toledo, OH 43614 ☐ Cleveland, OH 44131

Registration Fee: \$185 (Includes Lunch, Workbook and Spouse Attendance) 8:00 a.m. - 5:00 p.m.

Please Print or Type

Name _____

Address _____

City/State/Zip _____

Specialty _____ Telephone _____

My spouse: ☐ will ☐ will not attend.

My practice is: ☐ incorporated ☐ unincorporated

I am in a: ☐ group or partnership ☐ solo practice ☐ resident

Make check payable to: Black and Skaggs Associates

Mail to: **The PM Group**
 P.O. Box 1130, Battle Creek, MI 49016

Registration Form

MEDICAL COLLECTION MANAGEMENT WORKSHOP

- ☐ Wednesday, September 21, 1983 ☐ Thursday, September 22, 1983
 Ramada Inn ☐ Holiday Inn - Independence
 2340 S. Reynolds Road ☐ 6001 Rockside Road
 Toledo, OH 43614 ☐ Cleveland, OH 44131

Registration Fee: \$50 (per person) Includes Materials

- ☐ Morning Session - 8:00 a.m. - 12:00 p.m. (Check One)
☐ Afternoon Session - 12:30 p.m. - 4:30 p.m.

Please Print or Type

Names _____

Representing _____ Specialty _____

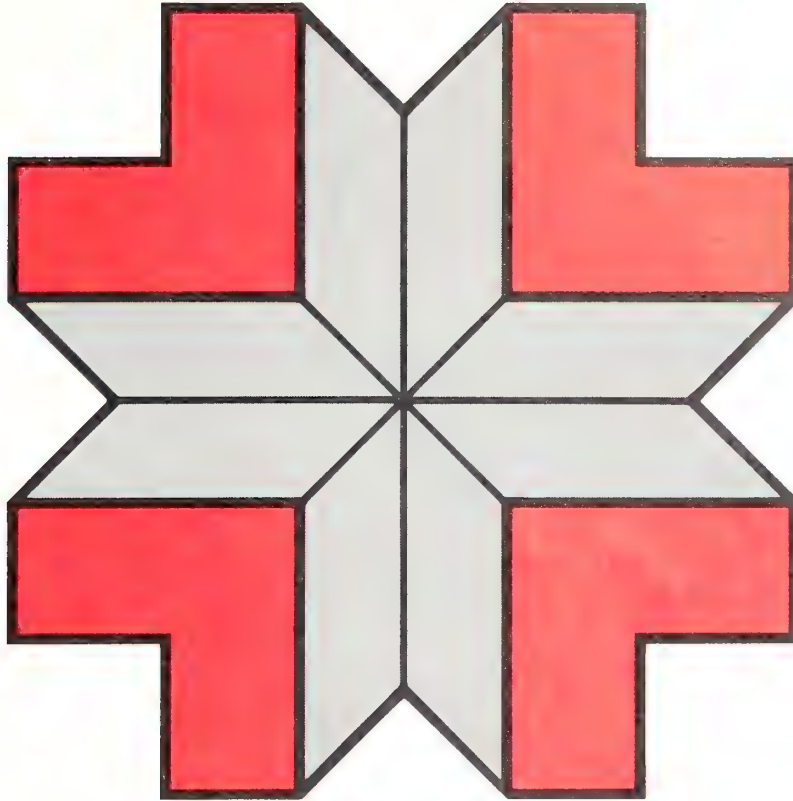
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Ohio Medicine at the Center

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Compare the quality of professional liability coverage ...not just price



Quality Checklist For Medical Professional Liability Insurance

	PICO	ANOTHER COMPANY
1. Services of actuarial consultants specializing in medical professional liability insurance	YES	_____
2. Rates based on actuarial data	YES	_____
3. Claims reserves based on actuarial data	YES	_____
4. Full disclosure of operating results and audited financial statements and notes	YES	_____
5. Detailed disclosure of claims data	YES	_____
6. Contractual profit sharing agreement	YES	_____
7. Physician consent for settlement of claim prior to judgement	YES	_____
8. Legal defense services provided only by specialists in defendant medical professional liability insurance suits	YES	_____
9. No pre-paid legal expense	YES	_____
10. Refusal to pay nuisance claims	YES	_____
11. Premiums to surplus ratio of less than 2-1	YES	_____
12. "Clean" opinion from auditors	YES	_____
13. Steady growth in surplus, claims reserves, and operating profits	YES	_____
14. Physician decisions on claims and underwriting matters	YES	_____
15. Official endorsement by the OSMA	YES	_____

When you're asked to compare the price of your medical professional liability insurance coverage, we suggest that you also compare quality. When your claim arises, now or several years in the future, the quality of your coverage, claims services, and the company standing behind you is what really matters.



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Effective July 1, 1983, PICO will increase its excess professional liability coverage limits by \$200,000, at no additional premium.

PICO's first layer of excess coverage will become \$1.2 million, at the same rate previously charged for \$1 million limits.

PICO excess policyholders will be contacted by mail shortly.

If you do not now carry PICO excess coverage, and you would like more information, return this card *today!*

Name _____

Office Address _____
Street

City _____ State _____ Zip _____

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Area Code

Coverage expiration date _____

Specialty _____

My primary coverage is now with:

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☐ Other carrier (Specify) _____



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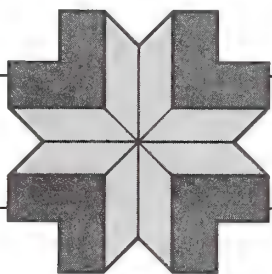
INDEX TO ACTIONS ON RESOLUTIONS

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	Repeal of 1974 Health Planning Act (PL 93-641) (By Academy of Medicine of Columbus and Franklin County)	2			



An overview of the House of Delegates, assembled at the Hyatt Regency Ballroom, Columbus, Ohio



**OHIO MEDICINE
at the
CENTER**

MAY 13-18, 1983

**Hyatt Regency/Ohio Center
COLUMBUS**

Highlights of '83

The OSMA Annual Meeting

This year proved to be an unusual one, with President C. Douglass Ford, M.D., Toledo, unable to preside, due to illness. However, he was certainly there in spirit — and later, on screen, to deliver his Presidential Address.

President-Elect, S. Baird Pfahl, M.D., Sandusky, got a running start this year, as he ably assumed presiding duties over this year's House of Delegates.

The House opened on . . .

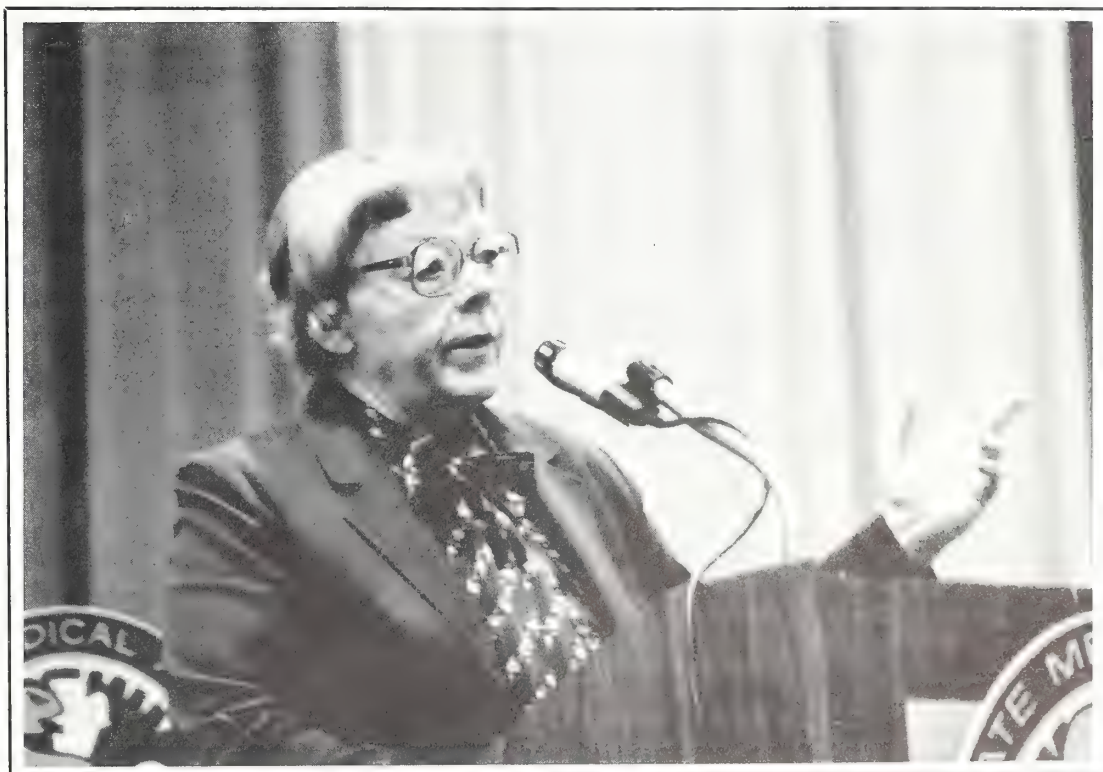
Friday night

After a welcome from James E. Barnes, M.D., President of the Academy of Medicine of Columbus and Franklin County, and some preliminary business, Betty Jane Anderson, J.D., Office of the General Counsel, American Medical Association, Chicago, was called to the podium to review the proposed JCAH Revisions for the House.



James E. Barnes, M.D.

Betty Jane Anderson, J.D., of the AMA's Office of General Counsel, explains one of the proposed JCAH revisions for the House.



Friday night

continued



Rose Vesper addressed the House in her role as Auxiliary President.



Anthony J. Ruppertsberg, M.D., Columbus, escorts OSMA staff member, Carol Maddy, to the front of the House for a special award. Ms. Maddy was being honored for 25 years of service to the Ohio State Medical Association.



Philip B. Hardymon, M.D., Columbus, entertained the House, while dispensing AMA-ERF checks to Ohio's medical schools.



Past President Stewart B. Dunsker, M.D., Cincinnati, awaits with plaque in hand, for the next retiring chairman of an OSMA committee to be recognized. Behind him are (left to right) John Ackerman, M.D., and Raymond McMahon, M.D., Massillon.

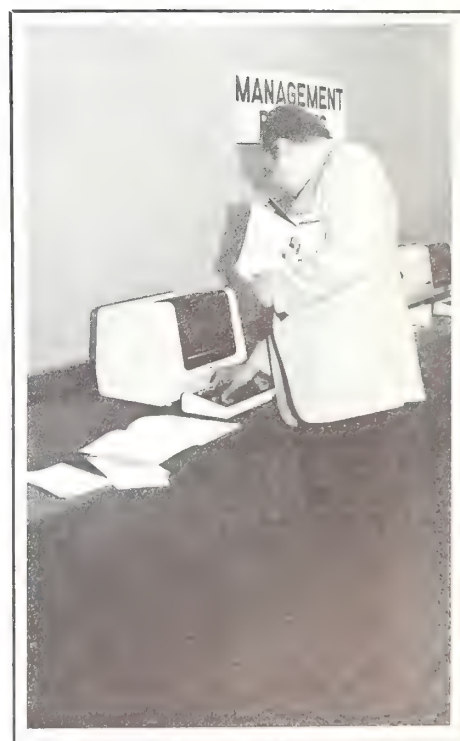


Members of the House watch President C. Douglass Ford, M.D., deliver his Presidential Address via videotape.

Saturday

A day for work as well as socializing. All three Reference Committees listened to testimony on their respective resolutions, then went to work, writing their recommendations for the House. In the meantime, there were a variety of social activities to attend: the OMPAC Luncheon (see related story, elsewhere in this issue); the Art and Culture theater party; and, of course, the ongoing activity at the Resource Center.

A seminar participant tests some of PACO's latest equipment at the Resource Center.



Sunday

The House reconvened Sunday afternoon to consider the resolutions and to participate in elections for members of Council and Delegates and Alternates to the AMA.

The first order of business was the election of the President-Elect.

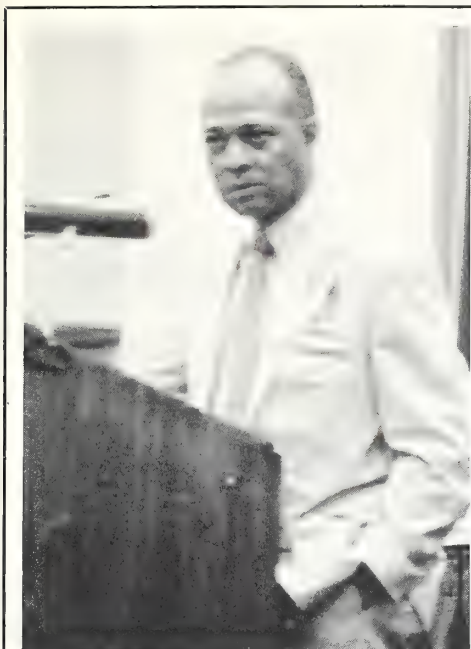
A. Burton Payne, M.D., Ironton, listens as he is announced OSMA's new President-Elect. Moments later, he joins the other officers on the front dais.



Then, committee reports are heard . . .

Members of Resolutions Committee No. 3 listen as their Chairman, James W. Wiggin, M.D., Mansfield, makes his report.





Roland Gandy, Jr., M.D., Toledo (left) and Leonard P. Rome, M.D., Cleveland, take their turns before the House as Chairmen of Resolutions Committees No. 1 and 2, respectively.

And, finally, the installation of Dr. Pfahl as President of the OSMA.



Stewart B. Dunsker, M.D., installs Dr. Pfahl, as Dr. Pfahl's wife, Phyllis (Fifi), his sons and his father, S. Baird Pfahl, Sr., watch.



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In hypertension, angina,
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Smooth 24-hour control

Unsurpassed simplicity
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Single daily dosage for
enhanced patient compliance

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80 mg



120 mg

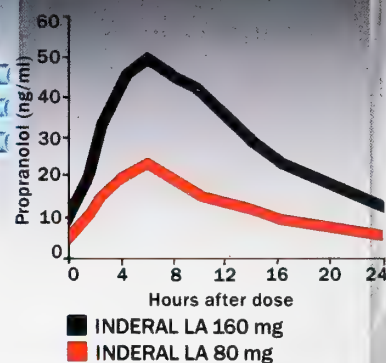


160 mg

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MEAN PLASMA LEVELS
ATTAINED WITH INDERAL LA
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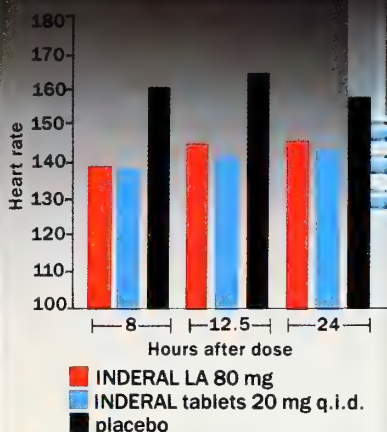
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In pharmacokinetic studies, blood levels with once-daily INDERAL LA were found to be adequate to maintain sustained clinical effect throughout 24 hours. The unique controlled-release formulation of INDERAL LA minimizes differences between peak and trough plasma concentrations.

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EFFECT ON POST-EXERCISE HEART RATE OVER 24 HOURS*



AND 24-HOUR BETA BLOCKADE

Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose—with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

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120 mg



160 mg

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*INDERAL LA vs. tablets: N.S. at all hours measured.

*INDERAL LA vs. placebo: $p < .05$ at all hours measured.

NEW
ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



**THE ONE
TO COUNT ON
FOR INITIAL
THERAPY IN HYPERTENSION**

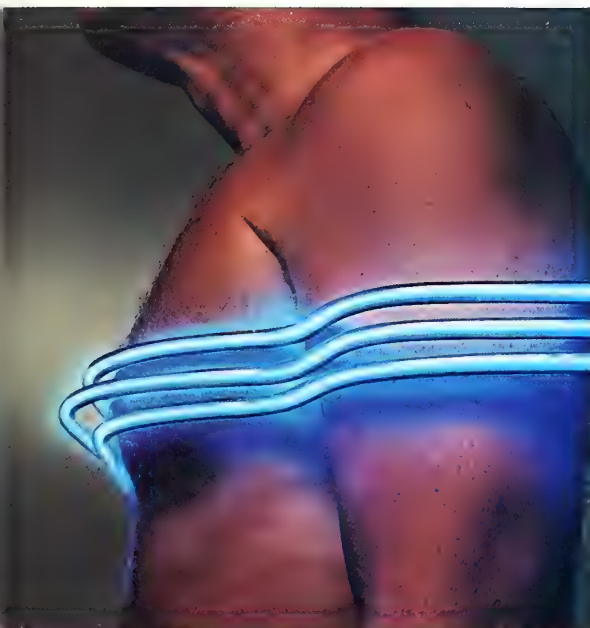
Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

**Unsurpassed convenience
and simplicity**

Enhanced patient compliance



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TO COUNT ON

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Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of INDERAL

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

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CAPSULES



80 mg

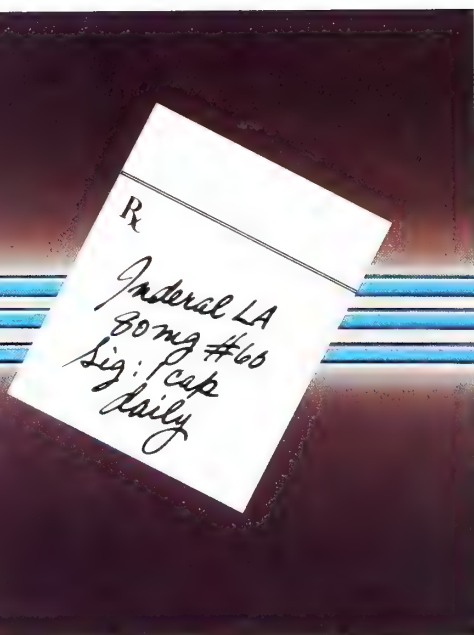


120 mg



160 mg

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THE EXPERIENCE
OF INDERAL
NOW WITH ONCE-
DAILY DOSAGE**

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In hypertension, angina, and
migraine—start with 80 mg
once daily

Smooth 24-hour control

Unsurpassed simplicity and
convenience

Enhanced patient compliance

Three strengths for prescribing
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For arrhythmias, use
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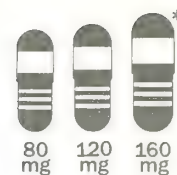
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ONCE-DAILY INDERAL[®] LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL[®] LA brand of propranolol hydrochloride (80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal LA is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal LA, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

Inderal LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

Inderal LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Inderal (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension, paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily in angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories.

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The 1983 Annual Meeting

PROCEEDINGS OF THE OSMA HOUSE OF DELEGATES

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7 PM, Friday, May 13, 1983, at the Hyatt Regency/Columbus at Ohio Center, Columbus, with the President-Elect, S. Baird Pfahl, Jr., M.D., presiding.

The invocation was offered by Dr. Lester Parker, Sandusky.

Dr. Pfahl introduced Goodwin Berquist, Ph.D., Department of Communications, The Ohio State University, the parliamentarian retained in accordance with Resolution No. 1-76.

Dr. James E. Barnes, Columbus, President of the Academy of Medicine of Columbus and Franklin County, welcomed the delegates, alternates and guests to Columbus.

Report of the Credentials Committee

Dr. John H. Budd, Cleveland, Chairman of the Credentials Committee, reported that of 220 members eligible to attend and vote, 171 were present, credentialed and seated. He also announced that included in this number were 14 specialty society delegates who qualified for representation under Chapter 4, Section 3 of the OSMA Bylaws. The Medical Student Section also was represented.

A number of alternate delegates, guests, officers of county medical societies, and executives were in attendance.

1982 Minutes Approved

The minutes of the 1982 sessions of the House of Delegates, as published in the July 1982 issue of The Ohio State Medical Journal, were approved by official action.

Dr. Schnebly Honored

At the request of Dr. Abromowitz, the House observed a moment of silence in honor of Frederic C. Schnebly, Dayton,

who died during the interim between sessions of the House.

Introduction of Others at Speakers' Table

Dr. Pfahl introduced others seated at the speakers' table who had not been previously introduced, as follows: Stewart B. Dunsker, M.D., Immediate Past President; David A. Barr, M.D., Secretary-Treasurer; James E. Pohlman, Esq., OSMA Legal Counsel; and Hart F. Page, CAE, Executive Director.

Introduction of AMA Board of Trustees Members

Dr. Pfahl introduced Joseph F. Boyle, Los Angeles, California, Chairman of the AMA Board of Trustees and John J. Coury, M.D., Port Huron, Michigan, Vice Chairman. Dr. Boyle addressed the House.

Introduction of AMA Associate General Counsel

Dr. Pfahl introduced B. J. Anderson, J.D., Associate General Counsel of the American Medical Association, who addressed the House. She presented an update on the most recent draft of the Medical Staff Section in the Accreditation Manual of the Joint Commission on Accreditation of Hospitals.

Introduction of OSMA Past Presidents

Dr. Pfahl first introduced the OSMA Honorary President, Dr. John H. Budd, Cleveland. Dr. Budd presented a few remarks to the House.

Then the following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. H. M. Clodfelter, Columbus; Dr. Charles L. Hudson, Bratenahl; Dr. Richard L. Meiling, Columbus; Dr. Robert E. Howard, Cincinnati; Dr. Robert N. Smith, Toledo; Dr. Oscar W. Clarke, Gallipolis; Dr. James

L. Henry, Grove City; Dr. George N. Bates, Toledo; Dr. William M. Wells, Newark; Dr. John J. Gaughan, Cleveland; Dr. Thomas W. Morgan, Gallipolis; Dr. Robert G. Thomas, Elyria; and Dr. Stewart B. Dunsker, Cincinnati.

Introduction of Past Members of the OSMA Council

Dr. Pfahl then introduced former members of the Council: Dr. Theodore J. Castele, Cleveland; Dr. Alford C. Diller, Van Wert; Dr. William Dorner, Jr., Akron; Dr. Philip B. Hardyman, Columbus; Dr. Stephen P. Hogg, Cincinnati; Dr. C. Edward Pichette, Youngstown; Dr. George J. Schroer, Sidney; and Dr. J. Hutchison Williams, Columbus.

AMA Past Presidents Introduced

Dr. Pfahl introduced the following AMA Presidents from Ohio: Dr. Charles L. Hudson, Bratenahl, 1966-1967; and Dr. John H. Budd, Cleveland, 1977-1978.

Medical Board Officers Introduced

Dr. Pfahl introduced Dr. Oscar W. Clarke, President, and Dr. Anthony Ruppertsberg, Jr., Secretary, of the Ohio State Medical Board.

Other Guests Introduced

Dr. Pfahl introduced the following: James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; and Steve Ellwing, Chicago, Illinois, AMA Medical Society Relations Department.

PACO Report

Dr. Herman I. Abromowitz, Dayton, Chairman of the Board of Physicians Administrative Corporation of Ohio, was introduced. Dr. Abromowitz gave a report on the current status of the company and a

summary of the activities and accomplishments of PACO in 1982. He also discussed future plans.

Mrs. Rose Vesper, New Richmond, Immediate Past President of the Ohio State Medical Association Auxiliary, was escorted to the podium by her husband, Dr. Lee J. Vesper. She addressed the House of Delegates and reported on 1982 activities of the Auxiliary.

Medicaid Committee Report

Dr. D. Ross Irons, Bellevue, was introduced and reported for the Ad Hoc Committee on Medicaid to the House.

AMA-ERF Checks Presented

Dr. Philip B. Hardyman, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation (AMA-ERF) was introduced, as was Mrs. Rose Vesper. Mrs. Vesper assisted Dr. Hardyman in the presentation of the AMA-ERF checks to Ohio's six medical schools.

It was announced that these contributions totaled \$70,839.07.

Certificate of Appreciation to Retiring Member of The Council

Dr. Stewart B. Dunsker, Cincinnati, received a certificate of appreciation in honor of his service to the Association as a member of the Council. Dr. Dunsker then addressed the House.

Certificates of Appreciation

The following members of Standing Committees and chairmen of Special Committees of the Association received certificates of appreciation for past service:

Dr. John H. Ackerman, Columbus, Committee on Education; Dr. Raymond J. McMahon, Massillon, Committee on Membership; Dr. John Thinnies, Cincinnati, Committee on Program.

Dr. A. Burton Payne, Ironton, Chairman, Committee on Auditing and Appropriations; Dr. Carl E. Spragg, New Concord, Chairman, Auxiliary Advisory Committee; Dr. John E. Albers, Cincinnati, Chairman, Committee on Association Structure; Dr. Ronald B. Berggren, Columbus, Chairman, Task Force on Competition and Marketing for Physicians; and Dr. Robert G. Thomas, Elyria, Chairman, Medical Student Liaison Committee.

SPECIAL AWARDS

A special certificate of appreciation was presented to Dr. William Dorner, Jr., Akron, for his service as a member of the Ohio Public Health Council.

A "long-suffering workhorse" award was presented to Dr. William Jeffries, Toledo,

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: 1. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

2. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: **General:** **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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*"I can do things that I
couldn't do for 3 yrs. including
joining the human race again."*



*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

*Procardia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA
(NIFEDIPINE) Capsules 10 mg

Please see PROCARDIA brief summary on adjoining page

Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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Dr. Ford's partner. He came forward to receive the award and received the applause of the House.

Reference Committee Chairmen Announced

The following House of Delegates Reference Committee chairmen were introduced by President Pfahl:

Credentials of Delegates — Dr. John H. Budd, Cuyahoga County; Tellers and Judges of Election — Dr. Claire V. Wolfe, Franklin County; Resolutions Committee No. 1 — Dr. Roland A. Gandy, Jr., Lucas County; Resolutions Committee No. 2 — Dr. Leonard P. Rome, Cuyahoga County; Resolutions Committee No. 3 and President's Address — Dr. James W. Wiggan, Richland County. Several changes in committee personnel were announced.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: First District — Dr. Harry H. Fox, Hamilton County; Second District — Dr. Jerry L. Hammon, Miami County; Third District — Dr. James H. Steiner, Logan County; Fourth District — Dr. Thomas J. O'Grady, Lucas County; Fifth District —

Dr. John J. Gaughan, Cuyahoga County; Sixth District — Dr. Raymond J. McMahon, Jr., Stark County; Seventh District — Dr. James Cottrell, Jefferson County; Eighth District — Dr. David L. Klein, Muskingum County; Ninth District — Dr. Thomas P. Price, Jr., Gallia County; Tenth District — Dr. Paul S. Metzger, Franklin County; Eleventh District — Dr. Charles Adams, Lorain County; Twelfth District — Dr. Francis J. Waickman, Summit County.

Dr. Pfahl announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Tenth District, Dr. Paul S. Metzger, Franklin County.

PRESIDENT'S ADDRESS

Dr. Pfahl then explained to the House of Delegates that since President C. Douglass Ford was unable to be present in Columbus for the annual meeting, his Presidential Address would be presented via video tape.

Upon completion of the presentation of the Address, Dr. Ford received a standing ovation.

Introduction of Out-of-State Guests

Dr. Pfahl introduced the following out-of-

state guests: Dr. Harry Shannon, Parkersburg, West Virginia, President, West Virginia State Medical Association and Mrs. Shannon. Dr. Robert P. Johnson, Springfield, Illinois, President, Illinois State Medical Society, and Mrs. Johnson. Dr. Donald K. Crandall, Muskegon, Michigan, President, Michigan State Medical Society. Dr. Dwight L. Blackburn, Berea, Kentucky, President, Kentucky Medical Association, and Mrs. Blackburn. Dr. George T. Lukemeyer, Indianapolis, Indiana, President-Elect, Indiana State Medical Association, and Mrs. Lukemeyer.

Introduction of Representatives of Allied Organizations

Dr. Pfahl introduced the following representatives of allied organizations: C. Milan Gorby, President, Ohio State Pharmaceutical Association; Dr. Duane J. Kerscher, President, Ohio Osteopathic Association, and Mrs. Kerscher; E. Gay Lindsay, President, Ohio Nurses Association, and Mr. Lindsay; Georgia M. McStraw, President-Elect, Ohio State Society of Medical Assistants, and Mr. McStraw; Dr. John E. Verhoff, President, Ohio Academy of Family Physicians, and Mrs. Verhoff; Herman N. Menapace, Chairman of the Board, Ohio Hospital

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For patient's comfort/convenience in choice of 3 strengths

Gradual Release LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
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Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
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Association, and Mrs. Menapace; Mrs. Lee J. Vesper, Immediate Past President, Ohio State Medical Association Auxiliary, and Dr. Vesper; Mrs. S. Baird Pfahl, Jr., President-Elect, Ohio State Medical Association Auxiliary.

Dr. Pfahl announced that the newly installed President of the Auxiliary is Stella Brown, (Mrs. John) Dayton.

Introduction of Resolutions

Dr. Pfahl announced that because the resolutions had been printed and distributed to the members of the House prior to the meeting and the assignment of resolutions to the Resolutions Committees had also been presented to the House in writing, individual introduction of the resolutions would be waived unless there were objections voiced by the House. There were none and the reading of the resolutions was waived.

25-Year Award to Carol Maddy

Mrs. Carol Maddy, Assistant Secretary of the House of Delegates, was escorted to the rostrum by Dr. Anthony Ruppberg, Jr., Columbus, to receive from President-Elect Pfahl a certificate and a gift in honor of her quarter-of-a-century of service to the Ohio

State Medical Association. Mr. Page recounted for the House some of her accomplishments during the 25 years.

Committee on Emergency Resolutions Report

The Committee on Emergency Resolutions reported that it had met earlier on May 13 to consider three emergency resolutions, as follows: (1) "OSMA/PICO," introduced by W. W. Tuckerman, M.D., Cuyahoga County; (2) "Tax Cap on Employee Benefits," introduced by OSMA District II Delegation and the Board of Directors of the Montgomery County Medical Society; and (3) "Preferred Provider Organizations (PPOs)," introduced by OSMA District II Delegation and the Board of Directors of the Montgomery County Medical Society.

The committee decided that only (1) "OSMA/PICO" met the criteria for an emergency resolution category and it was approved for submission to the House.

The report was filed by action of the House and the emergency resolution was numbered and referred as follows: OSMA/PICO, numbered 44-83, was referred to Resolutions Committee No. 2.

Dr. A. Robert Davies then moved to

suspend the rules so that the House could consider Emergency Resolution #3, entitled "Preferred Provider Organizations (PPOs)". The motion was seconded. After some discussion the House voted to suspend the rules and then voted to permit the resolution be considered by a resolution committee. The resolution on Preferred Provider Organizations (PPOs) was numbered 45-83 and was referred to Resolutions Committee No. 1.

Action Report on 1982 Resolutions

Dr. Pfahl announced that a report on the "follow-up" work on 1982 Resolutions had been distributed to the Delegates and Alternates prior to the First Session.

House Recessed

The House then recessed until the final session, 1:00 PM, Sunday, May 15.

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The 1983 Annual Meeting

PROCEEDINGS OF THE OSMA HOUSE OF DELEGATES

Minutes of the Final Session

The final session of the House of Delegates was convened at 1:00 PM, Sunday, May 15, 1983, at the Hyatt Regency/Columbus at Ohio Center, Columbus, with President-Elect S. Baird Pfahl, Jr., M.D., presiding.

Saslaw Award

Dr. Pfahl recognized Frank Papay, Past President of the Medical Student Section, who addressed the House. Mr. Papay then presented to Louis N. Saslaw a certificate from the Medical Student Section in appreciation of his work as coordinator.

Report of the Credentials Committee

Dr. John H. Budd, Cleveland, Chairman of the Credentials Committee, reported that out of 220 delegates eligible to vote, 196 were present, credentialed and seated.

Election of President-Elect

Dr. Pfahl called for nominations for the office of President-Elect. Dr. Thomas W. Morgan, Gallipolis, placed in nomination Dr. A. Burton Payne, Lawrence County, Councilor of the Ninth District. The nomination was seconded by Dr. Oscar W. Clarke, Gallipolis. There were no other nominations and Dr. Payne was elected by acclamation. Dr. Payne presented a brief statement of acceptance and was seated with the officers of the society at the rostrum.

Report of Nominating Committee

Dr. Paul S. Metzger, Delegate, Franklin County, Chairman of the Nominating Committee, presented the report of the Committee on Nominations as follows:

Councilors

Second District: As Councilor of the

Second District, to succeed himself, Dr. Herman I. Abromowitz, Dayton, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Abromowitz was declared reelected Councilor of the Second District for a term of two years, 1983-1985.

Fourth District: As Councilor of the Fourth District, to succeed himself, Dr. Benjamin H. Reed, Wauseon, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Reed was declared reelected Councilor of the Fourth District for a term of two years, 1983-1985.

Sixth District: As Councilor of the Sixth District, to succeed himself, Dr. J. James Anderson, Youngstown, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Anderson was declared reelected Councilor of the Sixth District for a term of two years, 1983-1985.

Eighth District: As Councilor of the Eighth District, to succeed himself, Dr. Carl E. Spragg, New Concord, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Spragg was declared reelected Councilor of the Eighth District for a term of two years, 1983-1985.

Tenth District: As Councilor of the Tenth District, to succeed himself, Dr. D. James Hickson, Mt. Gilead, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Hickson was declared reelected Councilor of the Tenth District for a term of two years, 1983-1985.

Twelfth District: As Councilor of the Twelfth District, to succeed himself, Dr. Joseph L. Kloss, Akron, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Kloss was declared reelected Councilor of the Twelfth District for a term of two years, 1983-1985.

Ninth District: As Councilor of the Ninth District, to succeed Dr. A. Burton Payne, Ironton, the Committee placed in nomination Dr. Thomas P. Price, Jr., Gallipolis. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Thomas P. Price, Jr., was declared elected Councilor of the Ninth District for a term of one year, 1983-1984.

AMA Delegates

Dr. Metzger then presented the nominees for the office of Delegate to the American Medical Association to serve a term beginning January 1, 1984 and ending December 31, 1985 (7 to be elected): Drs. John E. Albers, Cincinnati; Oscar W. Clarke, Gallipolis; Alford C. Diller, Van Wert; William Dorner, Jr., Akron; C. Douglass Ford, Toledo; John J. Gaughan, Cleveland; and B. Leslie Huffman, Jr., Maumee. The nominations were duly seconded and there were no further nominations from the floor. The nominees were elected unanimously, by acclamation.

At this time, Dr. Metzger commended Dr. George N. Bates, Toledo, for his past service on the Delegation. Dr. Bates had chosen not to run for another term. Dr. Bates received a standing ovation from the House, then responded with his thanks for the opportunity to serve.

AMA Alternates

For Alternate Delegate to the American Medical Association to serve a term beginning January 1, 1984 and ending December 31, 1985, the nominees were (7 to be elected): Drs. Herman I. Abromowitz, Dayton; David A. Barr, Lima; Edward E. Grable, Canton; Stanley J. Lucas, Cincinnati; Thomas W. Morgan, Gallipolis; Richard J. Nowak, Cleveland; H. Judson Reamy, New Philadelphia; Benjamin H. Reed, Wauseon; Lee J. Vesper, Cincinnati; and J. Hutchison Williams, Columbus. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Abromowitz, Barr, Grable, Lucas, Morgan, Nowak and Williams were declared elected.

REPORT OF RESOLUTIONS COMMITTEE NO. 1

Dr. Roland A. Gandy, Jr., Lucas County, as chairman, presented the report of Resolutions Committee No. 1:

Mr. President and members of the House of Delegates, Resolutions Committee No. 1 conducted open hearings and heard testimony on Resolutions No. 1-83 through 10-83, Resolution 45-83 and Report A of the Council.

RESOLUTION 2-83 — PROPOSED REVISION OF JCAH STANDARDS FOR HOSPITALS

RESOLUTION 3-83 — PROPOSED REVISIONS OF JCAH STANDARDS

The Committee considered Resolutions 2-83 and 3-83 together and in light of the information provided by B. J. Anderson and AMA Trustees, recommends the following Substitute Resolution in lieu of Resolutions 2-83 and 3-83.

SUBSTITUTE RESOLUTION 2-83 PROPOSED REVISIONS OF JCAH STANDARDS

BE IT RESOLVED, That the Ohio State Medical Association commend the leadership of the American Medical Association for their decision to work to retain and preserve the words "Medical Staff" in any proposed revisions of the Joint Commission on Accreditation of Hospitals standards; and be it further

RESOLVED, That the OSMA urge the AMA to continue to strive for the development of standards that provide for quality patient care, are flexible, meet the needs of physicians and hospitals, and recognize the legal aspects of standard-setting activities; and be it further

RESOLVED, That the Ohio State Medical Association and the Ohio Delegation to the AMA be encouraged to support the AMA in these efforts.

Mr. President, I move the adoption of Substitute Resolution 2-83.

By official action, the House voted to adopt Substitute Resolution No. 2-83.

RESOLUTION 4-83 — MEDICAL CARE COUPONS

Mr. President, the Committee heard considerable testimony on this resolution and there was sympathy expressed in regard to patients' rights. The Committee felt the idea of medical care coupons might be of interest to the OSMA Task Force on Medicaid. However, the Committee felt that the concept of medical care coupons was not made clear in the testimony and that the resolution was poorly drafted. For these reasons the Committee recommends Resolution 4-83 be rejected.

By official action, the House voted to reject Resolution No. 4-83.

RESOLUTION 5-83 — COMPETITION — FREE ENTERPRISE

The Committee felt this resolution did contain factual statements that could be supported by organized medicine, but it was the opinion of the Committee that the intent of the resolution was vague and unclear. For these reasons the Committee recommends that Resolution 5-83 be rejected.

By official action, the House voted to reject Resolution No. 5-83.

RESOLUTION 8-83 — RETROSPECTIVE REVIEW

Considerable testimony was received on this resolution. It was evident from the testimony that there was no support for any form of preadmission certification or preadmission review. The Committee was made aware of existing OSMA policy on retrospective review as contained in Resolution 42-79 opposing retrospective review. The Committee recommends Resolution 8-83 be rejected.

By official action, the House voted to reject Resolution No. 8-83.

RESOLUTION 9-83 — COST CONTAINMENT IN MEDICAL CARE

The Committee was made aware that OSMA currently has a Committee on Cost Effectiveness. This was not a controversial resolution. The Committee felt that editorial amendments were appropriate and recommends Resolution 9-83 be amended to read as follows:

AMENDED RESOLUTION 9-83 — COST CONTAINMENT IN MEDICAL CARE

Whereas, OSMA is on record as vigorously supporting cost containment in medical care; and

Whereas, Diagnostic and therapeutic procedures and other ancillary services may add significantly to the patient's medical and/or hospital charges; therefore be it

RESOLVED, That the OSMA through the Cost Effectiveness Committee develop a continuing educational program for physicians on cost effective utilization of diagnostic and therapeutic procedures and ancillary services.

Mr. President, I move the adoption of Amended Resolution 9-83.

By official action, the House voted to adopt Amended Resolution No. 9-83.

RESOLUTION 45-83 — PREFERRED PROVIDER ORGANIZATION (PPO)

There was considerable testimony presented on this resolution. As a result of this testimony the Committee felt that a detailed analytical study of the involved issues was necessary. This could not be done in the limited time available to this Committee and resource material was not available in adequate amounts.

Therefore, the Committee recommends this resolution be referred to the Council with the instruction that a prompt informational report be rendered to the membership and further instructs the OSMA council and AMA delegation to develop guidelines as OSMA policy on PPOs similar to those presented in Resolution 45-83 and to instruct the AMA delegation to submit a resolution to the 1983 annual meeting based on these guidelines.

By official action, the House voted to refer Resolution No. 45-83 to the Council.

Resolution No. 45-83 reads as follows:

Whereas, The original concept of preferred provider organizations (PPOs) were described as industry based health care plans that encouraged employees to seek out the most inexpensive health care providers (preferred providers), but did not take away from the patient the freedom of choice of physician and hospital and thereby allowed free and honest competition among health care providers, and

Whereas, Hospital or physician organized closed panel types of PPOs (patients must go to a set panel and only one hospital) takes all economic decisions from the patient, restricts the patient's freedom of choice, and unfairly excludes certain physicians and hospitals from competing for various segments of the market, and

Whereas, Different preferred provider organization structures exist and several new designs have been offered since March 14, 1983 (the cutoff for OSMA resolutions to the 1983 House of Delegates); now therefore be it

RESOLVED, That the Ohio State Medical Association encourage preferred provider organizations that, 1) maintain for the patient the freedom of choice of hospital and doctors, 2) allow the patient to make economic decisions involving his health care, 3) retain honest competition for any segment of the marketplace, 4) allow any physician to join a hospital's PPO and 5) that seek to lower the health care costs of the community through a competitive system, and be it

RESOLVED, That the OSMA inform its membership about alternative PPO structures and provide interested members with additional information, and be it further

RESOLVED, That the Ohio State

delegation to the AMA encourage a similar national policy on this issue.

REPORT A — RESOLUTION 12-82, AUTHORITY FOR PEER REVIEW FUNCTIONS

The Committee heard extensive testimony detailing the advantages and disadvantages of OSMA becoming involved in PRO activities. It was the Committee's interpretation that approval of Report A does not mandate that Council enter into any PRO contractual obligation, but simply authorizes Council to proceed if Council feels that it is in the best interest of OSMA and its constituents.

Therefore, the Committee recommends that Report A be adopted.

By official action, the House voted to refer Resolution 12-82 (Report A) to the Council with the following instructions from the House:

Report A be referred to Council with a report to all delegates and county presidents within 90 days of receipt of the government's regulations, and the Council's suggestions for implementation of PRO prior to entering into any contract.

Report A reads as follows:

The 1982 House of Delegates referred Resolution 12-82 (Authority for OSMA Review Functions) to the Council "for research and study, but to be returned to this House of Delegates for its approval prior to any implementation."

On September 3, 1982, President Reagan signed into law the Tax Equity and Fiscal Responsibility Act of 1982 (PL 97-248). Included in this legislation is the Peer Review Improvement Act of 1982 which repealed the PSRO program and replaced it with the Utilization and Quality Control Peer Review Organization (PRO).

OSMA President C. Douglass Ford appointed an ad hoc committee to review Resolution 12-82 and further charged the committee to look into what posture the OSMA should take in regards to the new PRO program.

The ad hoc committee met on February 23, 1983, with legal counsel, and discussed at length various issues relating to peer review including the new PRO legislation and the current PSRO program that is being phased out. Legal counsel gave assurances that organized medical groups can conduct peer review activities relating to quantity and quality of care as well as medical necessity. He further reported that fee review activities could be organized and conducted under certain guidelines, however the ad hoc committee voted not to recommend the establishment of fee review activities at this time.

The ad hoc committee discussed peer review activities being conducted in the state including activities of county medical societies, organizations supported by medical societies, PSROs and private entrepreneurs.

The Peer Review Improvement Act of 1982 was discussed as well as Report G (I-82) of the AMA's Council on Medical Service which provided a thorough discussion of the legislation.

The ad hoc committee was of the opinion that there is a definite need for an umbrella type medical organization to oversee peer review activities under the new PRO legislation and to work with county medical societies in ensuring that physicians maintain control and direction over peer review.

Accordingly the ad hoc committee recommended to the Council that the OSMA posture itself to make a positive response to be the Professional Review Organization under PL 97-248. (This action is in lieu of Resolution 12-82.)

The Council on April 16, 1983 considered the recommendation of the ad hoc committee and discussed the pros and cons as to whether OSMA should seek to contract with the Health Care Financing Administration to be the PRO under PL 97-82. Comments in opposition to OSMA becoming involved with this legislation were:

- OSMA is opposed to the PSRO program; the PRO legislation is a similar program with a different name.
- OSMA has historically been opposed to government directed or sponsored peer review.
- The PRO will be required to demonstrate cost savings, possibly at the expense of quality care or patients' needs.
- There are too many uncertainties as rules have not yet been issued to implement the legislation.
- There are too many unanswered questions regarding costs and staffing of the PRO.
- Review activities under the PRO legislation will include individual physician office audit.
- This was tried once with MAI.
- Traditionally the OSMA does not contract with the federal government. Comments in support of becoming involved included:
 - This is an opportunity for organized medicine to direct and control peer review not only for the purposes of PL 97-248 but also for other groups such as self-insured companies, insurance companies and other government programs.
 - Provides an opportunity for peer review to be more than just a cost savings program when directed by physicians concerned with the quality of service.
 - Would provide for physicians conducting peer review activities rather than intermediaries, insurance companies or other groups inasmuch as physician groups are given priority in contracting as the peer review organization.
 - Provides a structure for local medical societies to have involvement in peer review activities.

Council recognized several issues needed to be addressed prior to the OSMA contracting under Public Law 97-248. The issues include, but are not limited to, the organizational role of the OSMA; financial

commitments of the OSMA to the program; the structure and system of reimbursement from government and third party payors; clarification of the objectives and "norms of performance" to be utilized in the reviews; and the procedure involved in review, determination, and appeals. These issues cannot be effectively answered until the regulations are promulgated.

Fully recognizing the controversial nature of the issue and the changed environment surrounding peer review as a result of the enactment of Public Law 97-248, the Council wishes the House to debate the issue.

After extensive review of the known advantages and disadvantages, the Council believes that the OSMA House of Delegates should authorize the Council to offer to negotiate an acceptable contract to become the Professional Review Organization for Ohio under Public Law 97-248.

RESOLUTION 1-83 Information Programs by Pharmaceutical Companies and Medical Appliance Manufacturers

The Committee placed Resolution 1-83 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, It has become evident that recently some pharmaceutical companies and medical appliance manufacturers have carried out informational campaigns aimed directly at the public; and

Whereas, A patient may not be in a position to evaluate such products objectively and therefore could make judgments about the course of therapy for his illness which might be adverse to his best interests; therefore be it

RESOLVED, That the Ohio State Medical Association encourage pharmaceutical companies and the medical appliance manufacturers to establish guidelines for marketing practices which will be in the best interest of the safety and well-being of the general public; and be it further

RESOLVED, That the Ohio Delegation to the American Medical Association submit a similar resolution at the next meeting of the American Medical Association House of Delegates.

By consent, the House adopted Resolution No. 1-83.

RESOLUTION 6-83 Workmen's Compensation Disability Determinations

The Committee placed Resolution 6-83 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The determination of permanent medical impairment is an important component of workmen's compensation disability; and

Whereas, Most determinations now performed are inconsistent and not reproducible; and

Whereas, This frequently leads to increased litigation, which subtracts from the patient's legitimate award; and

Whereas, To improve consistency in such determinations, the states of Nevada and Oklahoma have adopted legislation requiring use of the AMA Guides to the Evaluation of Permanent Impairment; therefore be it

RESOLVED, That the OSMA endorse the concept of consistent and reproducible workers' impairment determinations by mandatory use of the AMA Guides to the Evaluation of Permanent Impairment; and be it further

RESOLVED, That the OSMA Department of Legislation proceed as it deems proper to get appropriate legislation enacted in Ohio.

By consent, *the House adopted Resolution No. 6-83.*

RESOLUTION 7-83

Inequities in Third Party Reimbursement

The Committee placed Resolution 7-83 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The amount of the reimbursement by third-party carriers for a given medical or surgical procedure is not always consistent from one area of the state to another; and

Whereas, Variations also exist based on the specialty of the physician performing the procedure, and on the type of facility in which it was performed (i.e., hospital, freestanding urgent care center, private office); therefore be it

RESOLVED, That the OSMA determine the reasons for these differences in reimbursement levels, and inform its members thereof.

By consent, *the House adopted Resolution No. 7-83.*

RESOLUTION 10-83

Official Statements

The Committee placed Resolution No. 10-83 on the Consent Calendar and recommended its rejection.

By consent, *the House rejected Resolution 10-83.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 1, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE AND WAS FILED.

REPORT OF RESOLUTIONS COMMITTEE NO. 2

Dr. Leonard P. Rome, Cuyahoga County, as chairman, presented the report of Resolutions Committee No. 2:

Mr. President and members of the House of Delegates:

Resolutions Committee No. 2 met in open session at 8:00 a.m. on Saturday, May 14, 1983, and heard testimony on Resolutions 11-83 through 26-83, as well as

Emergency Resolution 1 and Report B.

RESOLUTION 12-83 — AMA REPORTS

Mr. President, the Committee recommends Resolution 12-83 be rejected. The Committee recommends that a complete list of AMA reports be published in the *OSMA Journal*.

By official action, *the House voted to refer Resolution 12-83 to Council*. The resolution reads as follows:

Whereas, Each year the various AMA Councils (Judicial Council, Council on Medical Service, Council on Medical Education, Council on Scientific Affairs) and Board of Trustees produce excellent, comprehensive reports on a variety of scientific, legal, social and educational issues; and

Whereas, Most of these reports are available only to AMA Delegates and Alternate Delegates attending the Annual and Semi-Annual meetings; and

Whereas, Only a very few of these excellent and informative papers reach the general AMA membership through publication in the *JAMA*; and

Whereas, Even those few papers published in *JAMA* do not reach those OSMA members who choose, for whatever reason, not to join the AMA; therefore be it

RESOLVED, That the OSMA investigate methods by which those otherwise unpublished reports may be made available to its entire membership.

RESOLUTION 13-83 — HOSPITAL MEDICAL STAFF SECTION

Mr. President, Resolution 13-83 is a proposed amendment to the OSMA Bylaws. Section 1, Chapter 15 of the OSMA Bylaws describes the method of amending the Bylaws and provides that a majority vote of the Delegates present at the session can amend the Bylaws "provided that the proposed amendment shall have been published in the *Journal* or mailed to all members of the Association at least thirty (30) days prior to the Annual Meeting." Because of the publishing deadline of the *Journal*, the above resolution was not published prior to this meeting. A first-class mailing to the entire OSMA membership was not done. Such a mailing would have cost the association at least five-thousand, four-hundred dollars (\$5,400) and was not considered cost effective.

The Committee concludes that this resolution cannot be considered by the OSMA House of Delegates without the House agreeing to suspend the rule requiring distribution of proposed amendments to the Bylaws to be published or mailed thirty (30) days prior to the Annual Meeting.

The Standard Code of Parliamentary Procedure (Sturgis) permits the House to suspend its rules by a two-thirds majority of those present and voting. A motion to

suspend the Rules is not debatable and cannot be amended. It takes precedence and must be decided immediately.

Mr. President, the Committee recommends to the OSMA House of Delegates that a motion to suspend the rules be made to permit consideration of Resolution 13-83 and I so move.

If the motion to discuss the rules of the House is approved by the House, then Mr. President, the Committee recommends Resolution 13-83 be adopted.

Resolution 13-83 was not published 30 days prior to the House of Delegates as required for Bylaws amendments. The House defeated a motion to suspend the rules to allow discussion on this resolution. *The House then approved a motion from the floor to instruct Council to establish a Committee on Hospital Medical Staff Section.*

RESOLUTION 14-83(B) — REVISED VOTING PROCEDURE

Mr. President, Resolution 14-83(B) is a proposed amendment to the OSMA Bylaws. Section 1, Chapter 15 of the OSMA Bylaws describes the method of amending the Bylaws and provides that a majority vote of the Delegates present at the session can amend the Bylaws "provided that the proposed amendment shall have been published in the *Journal* or mailed to all members of the Association at least thirty (30) days prior to the Annual Meeting." Because of the publishing deadline of the *Journal*, the above resolution was not published prior to this meeting. A first-class mailing to the entire OSMA membership was not done. Such a mailing would have cost the association at least five-thousand, four-hundred dollars (\$5,400) and was not considered cost effective.

The Committee concludes that this resolution cannot be considered by the OSMA House of Delegates without the House agreeing to suspend the rule requiring distribution of proposed amendments to the Bylaws to be published or mailed thirty (30) days prior to the Annual Meeting.

The Standard Code of Parliamentary Procedure (Sturgis) permits the House to suspend its rules by a two-thirds majority of those present and voting. A motion to suspend the Rules is not debatable and cannot be amended. It takes precedence and must be decided immediately.

Mr. President, the Committee recommends to the OSMA House of Delegates that a motion to suspend the rules be made to permit consideration of Resolution 14-83(B) and I so move.

If the motion to suspend the rules of the House is approved by the House, then Mr. President, the Committee recommends Resolution 14-83(B) be adopted.

Resolution 14-83(B) was not published 30 days prior to the House of Delegates as required for Bylaws amendments. The House defeated a motion to suspend the rules to allow discussion and consideration of this Resolution. Accordingly, Resolution 14-83(B) was not considered by the House.

RESOLUTION 15-83 — SINGLE SHOT VOTING

Mr. President, Resolution 15-83 is a proposed amendment to the OSMA Bylaws. Section 1, Chapter 15 of the OSMA Bylaws describes the method of amending the Bylaws and provides that a majority vote of the Delegates present at the session can amend the Bylaws "provided that the proposed amendment shall have been published in the *Journal* or mailed to all members of the Association at least thirty (30) days prior to the Annual Meeting." Because of the publishing deadline of the *Journal*, the above resolution was not published prior to this meeting. A first-class mailing to the entire OSMA membership was not done. Such a mailing would have cost the association at least five-thousand, four-hundred dollars (\$5,400) and was not considered cost effective.

The Committee concludes that this resolution cannot be considered by the OSMA House of Delegates without the House agreeing to suspend the rule requiring distribution of proposed amendments to the Bylaws to be published or mailed thirty (30) days prior to the Annual Meeting.

The Standard Code of Parliamentary Procedure (Sturgis) permits the House to suspend its rules by a two-thirds majority of those present and voting. A motion to suspend the Rules is not debatable and cannot be amended. It takes precedence and must be decided immediately.

Mr. President, the Committee recommends to the OSMA House of Delegates that a motion to suspend the rules be made to permit consideration of Resolution 15-83 and I so move.

If the motion to suspend the rules of the House is approved by the House, then Mr. President, the Committee recommends Resolution 15-83 be adopted with the following editorial changes:

RESOLVED, That Chapter 5, Section 7 of the Bylaws be amended by adding at the end of the third and last paragraph the following: No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one vote for any nominee.

Resolution 15-83 was not published 30 days prior to the House of Delegates as required for Bylaws amendments. The House defeated a motion to suspend the rules to allow discussion on and consideration of this Resolution. Accordingly, Resolution 15-83 was not considered by the House.

RESOLUTION 16-83 — PICO

Mr. President, the Committee recommends Resolution 16-83 be rejected. Testimony was overwhelmingly against this resolution.

By official action, *the House voted to reject Resolution 16-83.*

RESOLUTION 44-83 — OSMA/PICO

Mr. President, the Committee recommends Resolution 44-83 be rejected. The Committee took the position that a statement by the Ohio State Medical Association at this time would be inappropriate since the subject is in litigation.

By official action, *the House voted to reject Resolution 44-83.*

RESOLUTION 17-83 — CONTROL OF LOOK-ALIKE DRUGS AND OVER-THE-COUNTER DRUG ABUSE

Mr. President, the Committee recommends Resolution 17-83 be adopted as follows:

Whereas, There has been widespread distribution of imitation or look-alike drugs and capsules that have been created from over-the-counter drugs; and

Whereas, The American Medical Association has supported the discontinuance of look-alike drugs; and

Whereas, The State of Ohio has already developed legislation regarding this issue (HB 535, effective August 20, 1982); therefore be it

RESOLVED, That the Ohio State Medical Association develop informational literature and programs through physician members to educate parents and children as to the danger of look-alike drugs; and be it further

RESOLVED, That the Ohio State Medical Association develop informational literature and programs regarding the abuse of over-the-counter drugs.

By official action, *the House voted to adopt Resolution 17-83.*

RESOLUTION 18-83 — PRESCRIPTION ABUSE

Mr. President, the Committee recommends Resolution 18-83 be adopted, as follows:

Whereas, Fraudulent use of prescriptions to obtain drugs is a major component of the overall substance abuse problem in Ohio; therefore be it

RESOLVED, That the OSMA intensify its efforts at educating its members regarding prescription abuse, and in the ways in which physicians can reduce the opportunities for misuse of prescriptions; be it further

RESOLVED, That the OSMA continue and increase its cooperation with other agencies and organizations in monitoring prescription abuse, and in developing solutions to the problem of prescription abuse.

By official action, *the House voted to adopt Resolution 18-83.*

RESOLUTION 19-83 — MSS PRESIDENT AS DELEGATE

Mr. President, Resolution 19-83 is a proposed amendment to the OSMA Bylaws. Section 1, Chapter 15 of the OSMA

Bylaws describes the method of amending the Bylaws and provides that a majority vote of the Delegates present at the session can amend the Bylaws "provided that the proposed amendment shall have been published in the *Journal* or mailed to all members of the Association at least thirty (30) days prior to the Annual Meeting." Because of the publishing deadline of the *Journal*, the above resolution was not published prior to this meeting. A first-class mailing to the entire OSMA membership was not done. Such a mailing would have cost the association at least five-thousand, four-hundred dollars (\$5,400) and was not considered cost effective.

The Committee concludes that this resolution cannot be considered by the OSMA House of Delegates without the House agreeing to suspend the rule requiring distribution of proposed amendments to the Bylaws to be published or mailed thirty (30) days prior to the Annual Meeting.

The Standard Code of Parliamentary Procedure (Sturgis) permits the House to suspend its rules by a two-thirds majority of those present and voting. A motion to suspend the Rules is not debatable and cannot be amended. It takes precedence and must be decided immediately.

Mr. President, the Committee recommends to the OSMA House of Delegates that a motion to suspend the rules be made to permit consideration of Resolution 19-83 and I so move.

If the motion to suspend the rules of the House is approved by the House, then Mr. President, the Committee recommends Resolution 19-83 be rejected. The President-elect of the Medical Student Section testified that he did not want this matter considered at this session of the House of Delegates. Further, the Committee has taken the position that it is inadvisable to establish a precedent whereby the President of the medical societies represented in the House of Delegates would seek Delegate status by virtue of their office.

Resolution 19-83 was not published 30 days prior to the House of Delegates as required for Bylaws amendments. The House defeated a motion to suspend the rules to allow discussion on and consideration of this resolution. Accordingly, Resolution 19-83 was not considered by the House.

RESOLUTION 20-83 — HANDICAPPED CHILDREN

Mr. President, the Committee recommends Resolution 20-83 be adopted as follows:

Whereas, There are many infants that are alive today due to the efforts of the medical profession and the medical field; and

Whereas, Many of these infants are handicapped and have special needs; and

Whereas, It is important that the Ohio

State Medical Association members demonstrate interest in becoming involved in community projects; and Whereas, It is important to support programs and services which help a child with a handicap to develop to his/her fullest potential; and Whereas, The concern of Ohio State Medical Association for a handicapped child should not stop when the infant is discharged from the hospital; and Whereas, The Ohio State Medical Association is the only statewide Medical Association which is capable of speaking for all Ohio physicians; therefore be it

RESOLVED, That the Ohio State Medical Association show a continued concern for handicapped children by supporting such laws as Public Law 94-142 which guarantees the rights of children with handicaps to a free and appropriate public education.

By official action, *the House voted to adopt Resolution 20-83.*

RESOLUTION 21-83 — PROBLEMS OF THE SENIOR CITIZENS

Mr. President, the Committee recommends Resolution 21-83 be adopted, as follows:

Whereas, There is growing concern on the part of many senior citizens that their health care needs are not being met adequately; and

Whereas, It is necessary to assure that no citizen is denied access to needed health care services; therefore be it

RESOLVED, That the Ohio State Medical Association establish an ad hoc committee consisting of physicians appointed by the President of the Ohio State Medical Association and charged with studying the health care-related problems of senior citizens in the State of Ohio; and be it further

RESOLVED, That the Ohio State Medical Association encourage the American Medical Association to appoint an ad hoc committee to investigate the health care problems of senior citizens on a national level.

By official action, *the House voted to adopt Resolution 21-83.*

The chair ruled that in the last "RESOLVED" the words "encourage the American Medical Association" be interpreted to be an instruction that the Ohio Delegation submit a resolution to the AMA at its June meeting.

RESOLUTION 22-83 — VISION TESTING FOR DRIVERS

Mr. President, the Committee recommends Resolution 22-83 be adopted, as follows:

Whereas, The Ohio General Assembly is considering several bills requiring drivers in Ohio to have their vision tested as part of the relicensure procedure; and

Whereas, Adequate vision is essential for safe operation of a motor vehicle; and Whereas, Vision testing may reveal medical problems not suspected by the

patient; therefore be it
RESOLVED, That the OSMA support the passage of such legislation requiring vision testing for drivers.
By official action, *the House voted to adopt Resolution 22-83.*

RESOLUTION 24-83 — PROPOSED REGULATIONS FOR NON-PHYSICIANS

Mr. President, the Committee recommends Resolution 24-83 be adopted, as follows:

By official action, *the House voted to amend Resolution 24-83 as follows and adopted it. The resolution now reads as follows:*

AMENDED RESOLUTION 24-83 — PROPOSED REGULATIONS FOR NON-PHYSICIAN

Whereas, The Health Care Finance Administration has recently published changes in the proposed rules governing Conditions of Participation which define the requirements that hospitals must meet in order to participate in the Medicare and Medicaid programs; and

Whereas, The proposed regulations would alter the definition of "physicians," causing chiropractors, optometrists, podiatrists and nurse practitioners to be deemed "physicians" and thus permitting them to admit patients to some hospitals; and

Whereas, Full admission and treatment privileges for non-physicians may lead to increased utilization, needless admissions, and higher hospital costs, along with potential deterioration in the quality of hospital care; therefore be it

RESOLVED, That the Ohio State Medical Association make our intent known at the 1983 annual meeting of the American Medical Association House of Delegates by submitting a resolution to the effect that the AMA take the strongest possible stand against promulgation of regulations proposed in Subpart J, Section 1861 of the Social Security Act which would redefine the word "physician" to include chiropractors, podiatrists, optometrists, nurse practitioners and other non-physicians.

RESOLUTION 25-83 — MODIFICATION OF THE TORT SECTION OF THE OHIO REVISED CODE

Mr. President, the Committee recommends Resolution 25-83 be rejected. The disadvantages outweigh the advantages.

By official action, *the House voted to reject Resolution 25-83.*

RESOLUTION 26-83 — WRONGFUL DEATH STATUTE

Mr. President, the Committee recommends Amended Resolution 26-83 be adopted in lieu of Resolution 26-83, and I so move.

AMENDED RESOLUTION 26-83 WRONGFUL DEATH STATUTE

Whereas, Amended Substitute H.B. 322, the Ohio Wrongful Death Statute became effective February 5, 1982; and Whereas, Such statute can easily be used by plaintiffs in an attempt to circumvent and/or supplement the State of Ohio statutes regarding medical malpractice; now therefore be it

RESOLVED, That the legal department of the Ohio State Medical Association continue to carefully study the results of amended substitute H.B. 322 in order to determine whether this new Wrongful Death Statute is being used in an attempt to circumvent the Ohio medical malpractice statutes; and be it further

RESOLVED, That this study determine, if possible, what changes and/or amendments to the Wrongful Death Statutes are needed in order to prevent its use to circumvent the statutes regarding medical malpractice in the State of Ohio. The results of the study are to be reported at the 1984 OSMA House of Delegates.

By official action, *the House voted to adopt Amended Resolution 26-83.*

REPORT B — REPORT OF THE AD HOC COMMITTEE TO REVIEW HOUSE OF DELEGATES POLICY

Mr. President, the Committee recommends Report B be adopted with the addition of Resolution 14-79, Physician Manpower.

By official action, *the House voted to adopt Report B. The report recommended the following policies be retained:*

SUGGESTED POLICIES TO BE RETAINED — 1979 HOUSE OF DELEGATES PROCEEDINGS

- 3-79 Funds for Defense
- 4-79 Second Surgical Consultation
- 5-79 Insurance Coverage for Ambulatory Surgery
- 7-79 Physicians Insurance Company of Ohio
- 13-79 Supervision and Institutional Employment of Physicians' Assistants
- 14-79 Physician Manpower
- 17-79 Consent Calendar
- 19-79 Update of OSMA Policy
- 21-79 Reduction of Dues for Physicians in Their First Year of Practice
- 35-79 Cost Containment
- 41-79 Involuntary Servitude
- 42-79 Retrospective Review
- 43-79 PSRO
- 44-79 National Health Planning and Resources Development Act of 1974
- 45-79 Federal Discrimination Against Teaching Hospitals
- 47-79 Use of Social Security Numbers as Universal Identifiers
- 48-79 Socioeconomic and Political Courses

RESOLUTION 11-83

Commending E. Joel Davis

The Committee placed Resolution 11-83 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, E. Joel Davis, M.D., has, for many years, given very freely of both time and effort in his support of the Stark County Medical Society; and Whereas, E. Joel Davis, M.D., has been a faithful member of the Board of Trustees (and its predecessor the Council) of the Stark County Medical Society; and

Whereas, E. Joel Davis, M.D. has long been active in the Ohio State Medical Association as a representative of the Stark County Medical Society; now therefore be it

RESOLVED, That the Stark County Medical Society extends its gratitude and very best wishes to E. Joel Davis, M.D. upon his retirement from active practice.

By consent, *the House adopted Resolution 11-83.*

RESOLUTION 23-83

Repeal of 1974 Health Planning Act (PL 93-461)

The Committee placed Resolution 23-83 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The American Medical Association is on record as supporting the repeal of PL 93-641 and its amendments enacted in PL 96-79; and Whereas, HR 1358 has been introduced in the U.S. House of Representatives calling for the repeal of this legislation; therefore be it

RESOLVED, That the OSMA support HR 1358.

By consent, *the House adopted Resolution 23-83.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 2, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE AND WAS FILED.

REPORT OF RESOLUTIONS COMMITTEE NO. 3

Dr. James W. Wiggins, Richland County, as chairman, presented the report of Resolutions Committee No. 3:

Mr. President and members of the House of Delegates. Resolutions Committee No. 3 met in open session on Saturday, May 14, 1983 and heard testimony relating to Resolutions 27-83 through 43-83, and the President's Address.

RESOLUTION 28-83 — PHYSICIAN DISTRIBUTION RESOLUTION 29-83 — PHYSICIAN SURPLUS IN OHIO

The Committee considered these two resolutions together because they encompassed the same general topic. The Committee proposes a substitute resolution.

The Committee proposes a substitute resolution be adopted in lieu of Resolutions 28-83 and 29-83, and I so move. The House amended the substitute resolution to read as follows:

AMENDED SUBSTITUTE RESOLUTION 28-83 — PHYSICIAN MANPOWER

Whereas, there is continuing concern about the supply of physicians in the State of Ohio, and

Whereas, the OSMA House of Delegates in Amended Resolution 14-79 has called for a continuing assessment of physician manpower in cooperation with the Ohio medical schools; and Whereas, the OSMA is cooperating with the Ohio Board of Regents, the Ohio Department of Health, and the medical schools in such assessment, and

Whereas, the OSMA Task Force on Marketing and Competition is currently creating a computer program to make available more detailed information about physician supply and need, THEREFORE BE IT

RESOLVED, That the OSMA Committee on Health Manpower actively undertake a study of the problems of physician manpower, distribution, and specialty training in this state during the year 1983-1984, and to report to the House of Delegates at the 1984 Annual Meeting.

By official action, *the House adopted Amended Substitute Resolution 28-83.*

RESOLUTION 31-83 — DRUG AVAILABILITY

The Committee was entirely in favor of Resolution 31-83 with the exception of the first Whereas and recommends an amended resolution. The Committee recommends Amended Resolution 31-83 be adopted and I so move. The House amended Resolution 31-83 to read as follows:

AMENDED RESOLUTION 31-83 DRUG AVAILABILITY

Whereas, Recent rulings by the FDA have led to the disallowance of payments under Medicaid and Medicare programs for certain medications; and

Whereas, The FDA has proposed removing a number of combination drugs from the market because of alleged ineffectiveness; and

Whereas, Patients need many of these medications when considered effective by their physicians on the basis of their clinical judgment and their experience — regardless of the FDA's ruling; THEREFORE BE IT

RESOLVED, That every patient, private or welfare, should have available any drug approved by the FDA that his or her physician thinks is needed and helpful; and be it FURTHER

RESOLVED, That these FDA-approved drugs should be reimbursed by third party payer; and be it FURTHER

RESOLVED, That a similar resolution be introduced at the next AMA meeting.

By official action, *the House adopted the House Amended Resolution No. 31-83.*

RESOLUTION 32-83 — OSMA LOAN FUND FOR MEDICAL STUDENTS AND IMPAIRED PHYSICIANS

RESOLUTION 33-83 — FUNDING FOR OSMA PHYSICIAN EFFECTIVENESS PROGRAM

RESOLUTION 34-83 — OSMA IMPAIRED PHYSICIANS REHABILITATION FUND AND THE OSMA-ERF

RESOLUTION 35-83 — OSMA IMPAIRED PHYSICIANS REHABILITATION FUND

RESOLUTION 36-83 — OSMA IMPAIRED PHYSICIANS REHABILITATION FUND

RESOLUTION 37-83 — OSMA IMPAIRED PHYSICIANS REHABILITATION FUND

The Committee heard testimony regarding Resolutions 32-83 through 37-83 and recommends the following substitute resolution:

SUBSTITUTE RESOLUTION 32-83 SUPPORT OF OHIO MEDICAL EDUCATION AND RESEARCH FOUNDATION

RESOLVED, That Ohio State Medical Association ask its members to contribute voluntarily \$10.00 or more per year to the Ohio Medical Education & Research Foundation; and be it FURTHER

RESOLVED, That members could designate, if so desired, a specific fund or program within the Ohio Medical Education & Research Foundation (i.e. impaired/recovering physician loans, medical student loans, etc.) to receive their contributions; and be it FURTHER

RESOLVED, That additional funds for the Foundation be solicited from OSMA members as voluntary tax deductible contributions, and from other appropriate sources.

Mr. President, the Committee recommends Substitute Resolution 32-83 be adopted in lieu of 32-83 through 37-83, and I so move.

By official action, *the House voted to adopt Substitute Resolution 32-83.*

RESOLUTION 38-83 — CONTRACEPTIVE DEVICES FOR MINORS

It was recognized that some individuals have strong feelings in this area. The Committee also noted that by Resolution 10-73 that the OSMA has supported the treatment of minors without parental consent. The weight of testimony was definitely in favor of this resolution. Therefore, Mr. President, the Committee recommends Resolution 38-83 be adopted, and I so move.

By official action, *the House voted to adopt Resolution 38-83.* The resolution reads as follows:

Whereas, Teen-age girls wanting to obtain contraceptive materials without their parents' knowledge frequently go to clinics rather than to private physicians for this purpose; and Whereas, the Department of Health and

Human Services is continuing its efforts to promulgate a regulation that any Federally-funded clinic dispensing contraceptive devices to a female under 18 must so inform her parents in a registered letter; and

Whereas, This regulation constitutes an unwarranted intrusion into the privacy of the family and can only serve to exacerbate any problems in communication already existing between the girl and her parents — contrary to the stated purpose of the regulation, which is to foster increased communication between children and parents; and

Whereas, Teen-age girls may therefore choose to forego obtaining contraceptive materials even though they are sexually active, thus increasing their risk of unwanted pregnancies and abortions, which are unquestionably detrimental to their physical as well as their emotional health; therefore be it

RESOLVED, That the OSMA urge the DHHS to rescind this regulation, known popularly as the "squeal law"; and be it further

RESOLVED, That the OSMA encourage its members to be receptive to discussions from their teen-age patients regarding sexual activity and contraceptive materials, and further, to encourage teen-agers and parents to discuss this subject within the home as freely and objectively as possible.

RESOLUTION 39-83 — CORPORAL PUNISHMENT IN SCHOOLS

The Committee heard some moving testimony and viewed photographs regarding this resolution. We felt that some minor changes and a second Resolved clause were needed. The Committee recommends an amended resolution be adopted and I so move.

The House voted to amend the Amended Resolution 39-83, to read as follows:

AMENDED RESOLUTION 39-83 CORPORAL PUNISHMENT IN SCHOOLS

Whereas, the paramount consideration in any system of discipline must always be in the interests of the child, and the exercise of discipline must be perceived as part of the educational process and should help create a favorable atmosphere for the learning process; and

Whereas, Corporal punishment may have a harmful effect upon the child's psychosocial development, thus negating the school's traditional role of promoting positive mental, emotional, and psychological development; and

Whereas, Teachers are perceived by students as role models, and therefore should portray the most positive role image to maximize the student's mental, emotional and physical potential; and

Whereas, Children who are corporally punished at school frequently are the victims of physical or other forms of abuse or neglect in the home; and

Whereas, There are alternatives to corporal punishment which will effect behavioral changes in a more positive manner; and

Whereas, The use of abusive punishment makes no positive contribution to the child's ultimate emergence as an emotionally mature, competent individual with a capacity to achieve his full potential; THEREFORE BE IT RESOLVED, That the Ohio State Medical Association support the abolition of corporal and abusive punishment in schools throughout the State of Ohio with these exceptions,

1. Disarming a student
2. Breaking up fighting among students
3. Self protection of teachers, protection of students, or another teacher.

and so inform the Ohio State Board of Education and the school boards nationally of its action, and be it further

RESOLVED, That OSMA work with the Subcommittee on Child Abuse and Neglect of the Ohio Chapter, American Academy of Pediatrics, through its two OSMA representatives, in order to implement this policy.

By official action, the House adopted Amended Resolution 39-83, with the House amendments.

RESOLUTION 40-83 — HEALTH CARE FOR CHILDREN

The Committee heard testimony indicating apparent discrimination against newborn infants and children by the insurance industry in their writing of health insurance policies. The Committee felt that this issue could best be considered by the OSMA Council.

Mr. President, the Committee recommends the referral of Resolution 40-83 to the OSMA Council for implementation of the recommended study and report back in 1984 and I so move.

By official action the House voted to refer Resolution 40-83 to the Council. The resolution reads as follows:

Whereas, "Health Supervision Services" are those physician delivered or supervised services which involve a periodic general review of the child's physical, developmental and emotional health status as is consistent with the standards of medicine within the State of Ohio; and

Whereas, There are detectable and preventable diseases in children; and

Whereas, Due to economic restraints, parents may put off taking children, who need medical care, to see a physician; therefore be it

RESOLVED, That the Ohio State Medical Association, in cooperation with the insurance industry, study the feasibility

and cost effectiveness of providing comprehensive health insurance benefits to children.

RESOLUTION 41-83 — BOXING AS A HEALTH HAZARD

From testimony and Committee discussion, it was generally recognized that boxing is a highly dangerous and medically undesirable activity. It was also recognized that there is little or no possibility of making it illegal. The Committee therefore recommends the following amended resolution.

AMENDED RESOLUTION 41-83 BOXING AS A HEALTH HAZARD

Whereas, One of the main purposes of each contestant in boxing is to render the opponent unconscious, thus inflicting a cerebral concussion; and

Whereas, Numerous studies have established the frequency of progressive and permanent neurological deficits and death as a consequence of participation in boxing; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association:

- 1) Publicize the deleterious effects of boxing on the health of participants.
- 2) Encourage the elimination of boxing from amateur athletic programs as detrimental to the health of participants.
- 3) Commend the American Medical Association's Advisory Panel on Brain Injury in Boxing for its continuing efforts to minimize the physical dangers of this activity.
- 4) Work with the Ohio General Assembly for the adoption of model legislation for the control of boxing and "Tough Man contests" as has been proposed by the AMA Department of State Legislation, Division of Legislative Activities.

Mr. President, the Committee recommends Amended Resolution 41-83 be adopted, and I so move.

By official action, the House voted to reject Amended Resolution 41-83.

After the defeat of Amended Resolution 41-83, a Substitute Resolution 41-83 was presented to the House by the Fifth District Delegation:

SUBSTITUTE RESOLUTION 41-83 — BOXING AS A HEALTH HAZARD

Whereas, One of the main purposes of each contestant in boxing is to render the opponent unconscious, thus inflicting a cerebral concussion; and

Whereas, Numerous studies have established the frequency of progressive and permanent neurological deficits and death as a consequence of participation in boxing; therefore be it

RESOLVED, That the Ohio State Medical Association:

- 1) Publicize the deleterious effects of boxing on the health of participants.
- 2) Encourage the elimination of boxing

from amateur, scholastic, intercollegiate and governmental athletic programs as detrimental to the health of participants.

- 3) Develop model legislation seeking to curtail the utilization of boxing as a public spectacle.

AND BE IT FURTHER

RESOLVED, That the Ohio Delegation to the American Medical Association submit a similar resolution at the next meeting of the American Medical Association House of Delegates.

AND BE IT FURTHER

RESOLVED, That the Ohio State Medical Association work with the Ohio General Assembly for the adoption of model legislation for the control of boxing and "Tough Man contests" as has been proposed by the AMA Department of State Legislation, Division of Legislative Activities.

By official action, *the House voted to adopt Substitute Resolution 41-83.*

RESOLUTION 42-83 — OHIO STATE MEDICAL BOARD

It became apparent that the concern of the author of this resolution primarily involved problems with communications. Therefore, the Committee recommends the following substitute resolution.

SUBSTITUTE RESOLUTION 42-83 OHIO STATE MEDICAL BOARD

Whereas, Many physicians are unaware of the organizational structure of the Ohio State Medical Board and the rules and regulations by which it is governed; and

Whereas, Some decisions made by the Ohio State Medical Board in dealing with those convicted of felonies and serious misdemeanors may appear inconsistent in the eyes of some physicians in this state; THEREFORE BE IT

RESOLVED, That the OSMA periodically inform its membership as to the organizational structure, rules and regulations of the Ohio State Medical Board; and be it FURTHER

RESOLVED, That OSMA Council develop, in cooperation with the Ohio State Medical Board, methods of informing the membership of formal disciplinary actions taken by the Ohio State Medical Board.

Mr. President, the Committee recommends Substitute Resolution 42-83 be adopted in lieu of Resolution 42-83, and I so move.

By official action, *the House voted to adopt Substitute Resolution 42-83.*

PRESIDENT'S ADDRESS

Dr. Ford acknowledged the contributions of many others in the accomplishments of our organization during the past year, including the OSMA Auxiliary and our superb OSMA staff.

Dr. Ford went on to express his concerns (and our concerns) about the ultimate effects of new systems of reimbursement, such as the Advance Plan, PPOs, and EPOs

as well as TEFRA. A common thread of concern was the potential loss of the patient's freedom of choice.

Dr. Ford's closing thoughts dealt with the quality of individual physicians. He chided us to clean our own house, dealing harshly with "the physician with a larcenous heart," but also warned us not to be too quick to judge without understanding all the facts.

The Committee felt the same disappointment expressed by Dr. Pfahl that Dr. Ford was unable to be among us. We commend him for an excellent job under trying circumstances.

By official action, *the House voted to file the report.*

RESOLUTION 27-83 OSMA Auxiliary Commendation

The Committee placed Resolution 27-83 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, OSMA is on record as supporting development of comprehensive health education programs in Ohio's elementary and secondary schools; and

Whereas, Assessment of the present level of health education is necessary before new and improved programs can be developed; therefore be it

RESOLVED, That the Ohio State Medical Auxiliary be commended for its outstanding achievement in assessing health education policies, programs, and procedures in 51 local school districts to date. These districts include more than ten percent of Ohio's entire elementary and secondary school enrollment.

By consent, *the House adopted Resolution 27-83.*

RESOLUTION 30-83 Therapeutic Substitution

The Committee placed Resolution 30-83 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The American Society of Hospital Pharmacists has endorsed the concept of therapeutic substitution — a measure that would give the pharmacist the right to substitute drugs within a therapeutic class even though they may not be in a similar chemical or pharmacological class — e.g. aspirin for indomethacin (anti-inflammatory) or ampicillin for a cephalosporin (antibiotic); and

Whereas, The American Pharmaceutical Association only narrowly voted down a similar resolution at its annual meeting; and

Whereas, The physician is the only person with the available knowledge and records regarding each patient's medical problems and possible reactions to medications; and

Whereas, This does not serve the welfare of the patients; therefore be it

RESOLVED, That the OSMA vigorously oppose any concept of substitution and

carry a similar resolution to the AMA. By consent, *the House adopted Resolution 30-83.*

RESOLUTION 43-83 Sexual Harassment

The Committee placed Resolution 43-83 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, Sexual harassment still exists in the workplace; and

Whereas, Sexual harassment is discriminatory and degrading, and is completely inappropriate in today's environment which strives to preserve human rights and equality for all members of society; and

Whereas, Sexual harassment is detrimental to the health and well being of all employees, whether victims or their co-workers, in that it can cause anxiety and actual psychophysiological illness, and moreover, contributes directly to dissension, inefficiency, and low morale among employees; therefore be it

RESOLVED, That the OSMA encourage its members to work toward the eradication of sexual harassment where it exists in their institutions and offices, and in all other workplaces.

By consent, *the House voted to adopt Resolution 43-83.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 3, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE AND WAS FILED.

INAUGURAL CEREMONY

Dr. James Hart escorted Mrs. Pfahl, the Pfahl's four sons — Scott, Doug, Dan and Todd, and Mr. Stannard Pfahl, Dr. Pfahl's father, to the rostrum.

Dr. Dunsker administered the Presidential Oath of Office to Dr. Pfahl.

Dr. Pfahl then introduced the members of his family to the House. He also presented his father-in-law, Dr. H. R. Boiman and the members of his office staff who were in attendance, (Kathleen Canterbury, Betty Foster, Julie Huber, Linda Renward and Peter Walderzak).

The Pfahl family was then seated.

Dr. Dunsker then presented to Dr. Pfahl the official gavel and the President's Medallion.

Dr. William Jeffries was asked to come to the rostrum to accept for Dr. and Mrs. Ford the past president's pin, the president's certificate, replica of president's medallion for Mrs. Ford and replica of president's medallion for Dr. Ford.

Dr. Pfahl then addressed the House as the new OSMA President.

There being no further business, the House of Delegates then adjourned, sine die.

ATTEST: Hart F. Page, CAE
Executive Director
and
Carol C. Maddy
Assistant Secretary
House of Delegates

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OMPAC Luncheon



John McLaughlin

Capitalism . . . and Cows

By Carol Wright Mullinax

What does capitalism have to do with cows? John McLaughlin, Chief Washington Editor of the *National Review* and host of television's McLaughlin Group, explained it to a capacity crowd at the Ohio Medical Political Action Committee's luncheon held during Annual Meeting.

McLaughlin, a conservative and champion of free enterprise, said most of the world's political systems could be summarized by a parable he learned at his father's knee:

Under socialism, if a man has two cows, he must give one to his neighbor.

Under capitalism, if a man has two cows, he sells one and buys a bull. McLaughlin's message to Ohio physicians and spouses: the market is ripe for bull buying.

Citing a wide variety of internal and external factors, McLaughlin said, "Capitalism as an economic philosophy is on the ascendency." He identified four internal factors that he felt has led to this change: Reaganomics, the media, academia and business.

An entertaining as well as informative speaker, McLaughlin had nothing but good news about the

Under capitalism, if a man has two cows, he sells one and buys a bull. The message for Ohio? The market is ripe for bull buying.

Under communism, if a man has two cows, he must give them both to the government and the government will give him milk.

Under facism, if a man has two cows, he keeps the cows, gives the milk to the government and the government sells it back to him.

Under Nazism, if a man has two cows, the government shoots the man and keeps the cows.

economy. He said, thanks to President Reagan, the country is at the beginning of a "broadly-based economic recovery" which has resulted in growing consumer confidence. One important side effect of this good fortune has been a total recalibration of the political scene. As McLaughlin put it: "With Ronald Reagan's stock in ascension" the country is experiencing
continued on page 525

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Capitalism . . . and Cows

continued

a cultural shift back to conservative values and beliefs.

He pointed with pleasure to the fact that the media has already begun to be affected by this shift. Although still too liberal for his tastes, McLaughlin acknowledged that the media is attempting to balance its coverage of the news - particularly economic news - by educating reporters to cover economic news intelligently.

While McLaughlin is excited about this good sign from the media, it is another world — academia — in which he sees the most "vast and exciting changes" taking place.

Capitalism is no longer a dirty word on our college campuses . . . it is no longer chic to be Marxist in the college scene . . .

"Capitalism is no longer a dirty word on our college campuses," McLaughlin exulted, pointing to the fact that students today can study capitalism without negative connotations. He credits this to a change in attitude among professors: "Intellectuals no longer sneer at business and capitalism; it is no longer chic to be Marxist in the college scene." He said this is a far cry from the time he served as a speechwriter for President Nixon and was forbidden to use the word "capitalism" in speeches.

This negative attitude toward capitalism extended to the people who operated it as well as the system itself. For many years, according to McLaughlin, businessmen "failed to capture the hearts of the American people." But their deportment has changed in recent years and the public is beginning to look at business people

continued on next page

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1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME: Philadelphia, Lea & Febiger, 1980, p. 1114.

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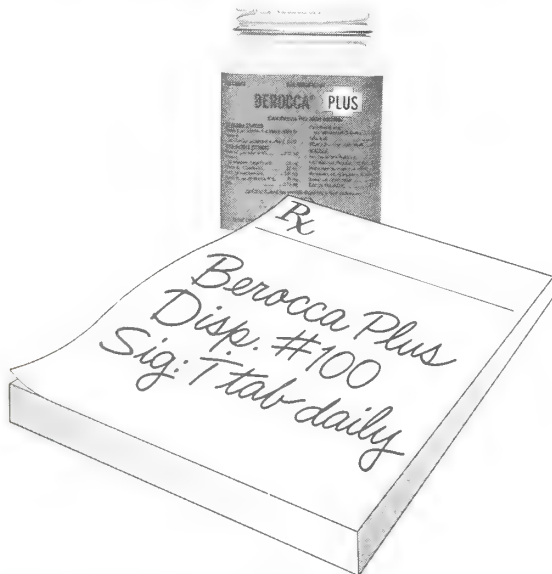
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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

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Capitalism . . . and Cows

continued

in a new light. Pointing to the recent Tylenol poisoning scare in which Johnson and Johnson "acquitted themselves with dignity and honor," McLaughlin congratulated businessmen for finally "taking their code of ethics out of the frame on the wall and putting it to use."

At a time when things seem finally to be coming together for this country, conditions are beginning to deteriorate in Russia

McLaughlin also reported that the situation is changing on the international as well as national scene. At a time when things seem finally to be coming together for this country, conditions are beginning to deteriorate in Communist Europe and Russia. McLaughlin predicted that things may really change for the United States vis-a-vis Communist countries when President Reagan gets reelected (McLaughlin's convinced he will run and - if the economy keeps improving - be living on Pennsylvania Avenue until 1988). He said Reagan has already started to spend more time on foreign policy and is gaining more self-assurance in that area. If Reagan gets "hooked" on the idea of peace (as he has on no "new taxes") McLaughlin is certain Reagan can do "extraordinary things" and this country's reputation in the world will be enhanced.

In all, McLaughlin said, "We can be optimistic about the free enterprise system" and it was easy to see why he felt the world situation was "bullish."

Carol Wright Mullinax is the Associate Director, Department of Communications, the Ohio State Medical Association

Untangling the Mind

By Gina DiBlasio Cummins

With more and more stresses occurring in today's society, the practice of psychiatry has had to evolve necessarily into new areas and techniques of practice.

Here's a glimpse of how the field of psychiatry is adjusting to the complex task of untangling the human mind.



The basic element of psychiatric treatment is the data the psychiatrist gathers through the interview process.

Anorexia, agoraphobia and divorce/custody battles may be making today's headlines, but they are not new problems. True, they occur with more frequency, and in greater numbers, but they have always existed. Because these problems and disorders did not receive as much attention even 10 years ago, many individuals suffered in private — afraid and embarrassed to seek help.

Thanks to the widely publicized advances in medicine, particularly in the field of psychiatry, there is increased professional help and new treatment methods available.

To help untangle the fine strands of the human mind, ongoing research and studies in the field of psychiatry have enabled physicians to better understand the mental problems and disorders prevalent in today's society.

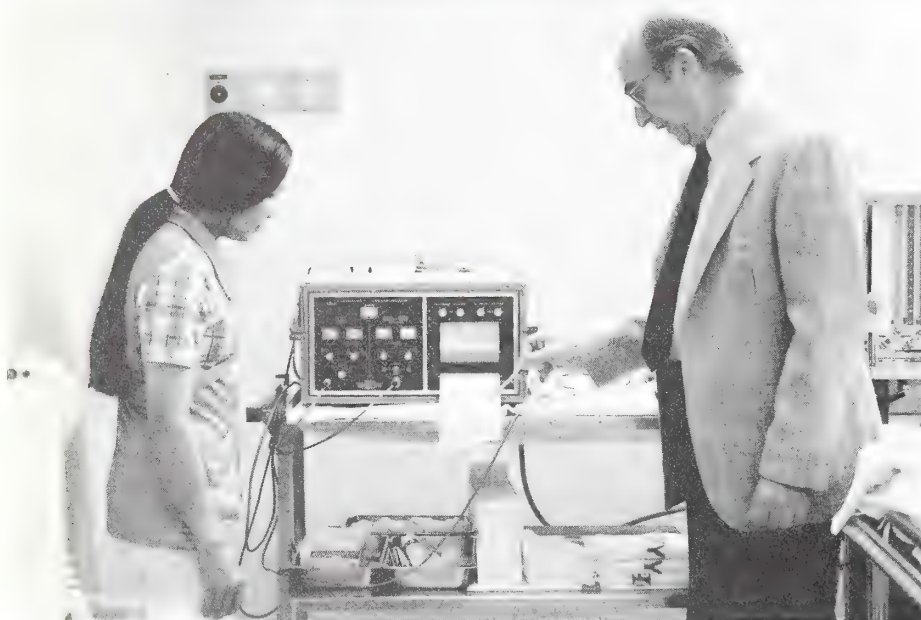
One of the most effective treatment methods being employed more

One of the most effective treatment methods is the doctor/patient consultation in conjunction with medication

frequently is ongoing psychiatric evaluation and psychotherapy even when psychotropic medication is used, according to Bernard Kuhr, M.D., president of the Ohio Psychiatric Association and director of mental health services at Riverside Hospital in Columbus, and Roslyn Seligman, M.D., a Cincinnati psychiatrist and past president of the Ohio Psychiatric Association.

continued on next page

Dr. Kuhr says that psychiatrists are consulting more and more with pharmacists before prescribing medication for a patient in order to avoid potential drug reactions.



Dr. Kuhr examines the latest electro-convulsive therapy equipment which produces an ECG and EEG tracing throughout the treatment period. It also modifies the electric current of the patient's brain to reduce side effects of post-treatment confusion.

Psychiatry. Untangling the Mind

continued

Both psychiatrists feel that this emphasis on "individualizing" treatment by thoroughly familiarizing oneself with the patient, can prove extremely useful in detecting other underlying disorders or concerns which may be affecting the patient's main complaint. "Systematic inquiry can produce a great payoff by revealing aspects of an individual he may not have previously confided in says Dr. Kuhr. He says that by asking a patient whether he has recently experienced grief, sleep disorders, agoraphobia, blank spots (loss of time) or involvement with alcohol or drug use can help determine the real nature of the problem. In addition to talking to a patient, Dr. Seligman feels that listening to a patient without preconceived ideas is just as important. "By listening to a patient, you can better understand the patient and more easily determine the cause and treatment required." Both

The doctor/patient relationship is so important that he encourages physicians to obtain a consultation with a psychiatrist on how to manage a patient

psychiatrists feel that this doctor/patient relationship is so important that they encourage physicians to sometimes obtain a consultation with a psychiatrist on how to manage a patient, rather than simply referring a patient to a psychiatrist. "If the physician spends time discussing the patient's problem with a psychiatrist, a better understanding of the problem can be gained and perhaps future recognition in other cases," says Dr. Kuhr.

In addition to better understanding

through extensive interviewing, Dr. Kuhr discusses other new techniques and theories which recently have shed light on various areas in psychiatry:

Schizophrenia

- Studies have shown that the risk of leaving a schizophrenic patient defenseless against a relapse can be minimized if both the patient and family are taught to recognize the early signs of recurring psychosis, such as anxiety and sleeplessness.

- A newer, more effective way of stabilizing a schizophrenic patient can be achieved by combining a lower dosage of medication with intermittent use.

- With the help of psychiatrists, schizophrenic patients now are learning what kinds of circumstances may trigger their psychotic symptoms in order to avoid or cope with them. Many of these circumstances are the same situations that would make a non-schizophrenic merely anxious or angry.

- Brain imaging techniques that employ color mapping of data are a great boon to schizophrenic research. The color topography of regional differences in the brains of normal subjects and in schizophrenics, allows for succinct and easily assimilated comparisons of data from a variety of imaging techniques.

Depression

- There is now a growing emphasis on the need to consider and rule out organic illness before concluding that a patient has a primary depressive disorder to be treated with anti-depressants. The psychiatrist systematically evaluating the depression often detects signs of underlying physical disorders and the need to initiate additional medical evaluation.

- In cases presenting difficult diagnostic problems, three biological tests now can be used to confirm the diagnosis of depressive affect disorders. If all three tests, the DST (Dexamethasone suppression test), the TRH (Thyroid Releasing Hormone test)

and a new neuroendocrine test (platelet serotonin transport) are conducted and turn out positive, they can confirm a depressive disorder in 96% of patients.

Premenstrual syndrome (PMS)

- When diagnosing and treating PMS, multiple factors (psychological, social and physical) must be considered. It is necessary to involve the patient in the therapy to assess the interaction of these factors since merely prescribing medication often leaves the patient feeling abandoned.

Neurobiology of Panic Disorders and Agoraphobia

- Research has found that the Locus coeruleus, is the principal brain nucleus of adrenalin-like responses. It is located in the pons and sends out signals to various parts of the brain and spinal cord. When activated in animals, it stimulates a panic state. This finding is significant because it opens avenues for the development of new drugs to treat and curtail anxiety and panic responses in humans.

- Psychiatrists have found that infusions of lactate can induce panic states — a new diagnostic and research tool.

- Studies show that fluorescent lighting increases symptoms of agoraphobia but these symptoms will diminish with successful treatment.

Anorexia

- Many women with anorexia have great difficulty returning to normal weight and some continue to have anorexic thoughts and behavior even after weight recovery. These women have a deficiency of nor-epinephrine. This deficiency may produce a failure for an individual to return to normal weight after recovery or may reflect a susceptibility to developing anorexia.

Organic Impulsivity

- Attention deficit disorder (ADD), is the most common form of hyperactivity in children. Studies show that similar cognitive and behavioral manifestations also occur in adults.



Roslyn Seligman, M.D., Cincinnati

“Since there is such an important research linkage between psychiatry and other fields such as radiology and neurology, I hope to see more collaboration between psychiatry and these other medical specialties in the future”

— Roslyn Seligman, M.D.

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Psychiatry. Untangling the Mind

continued

- Studies also show that stimulant responsive children may show either impulsive, inaccurate responses, or delayed, but accurate answers. In both types, stimulant correction of the attention deficit normalizes the reaction — slowing the fast reaction and speeding up the slow one.

- In adults, and especially in children and adolescents, there may be an underlying affective illness which is masked or overshadowed by an impulse disorder. Impulsive personalities often can present with delinquent or criminal behavior, alcohol or substance dependent individuals, or as child and spouse abusers.

Posttraumatic Stress Syndrome

- Recent studies have shown that many of the Vietnam veterans that complain of recurring nightmares may

not be the reliving of these events out of fear and terror as originally believed. Extensive surveys have shown that many of these men have a very low boredom threshold and, consequently, led an extremely active lifestyle prior to the war. While under stress in Vietnam, they were very relaxed and even enjoyed the excitement of combat. However, once they returned home, they were suddenly deprived of the intense excitement they thrive on. In order to compensate for this deprivation, they generate their own stimulation by unconsciously recalling these events through nightmares. This hunger of intense stimulation may be related to something in the nervous system (stimulus underload) which makes some people calm under external pressure or excitement, and exceptionally bored when leading a normal life.

Dr. Seligman notes that many of the advances which have been made in the various areas of psychiatry are partially due to advances in other

specialties, such as neurology, endocrinology, and radiology. Several new radiologic techniques, including computerized tomography and positron emission tomography have improved the psychiatrist's ability to study the brain and make new diagnoses. "Since there is such an important research linkage between psychiatry and other fields such as radiology and neurology, I hope to see more collaboration between psychiatry and these other medical specialties in the future."

Both Drs. Kuhr and Seligman feel that as technology continually progresses, the field of psychiatry will be able to provide an even greater service to people who need help gaining control over disordered emotional states and obtaining freedom from the imprisoning web they have spun around their lives.

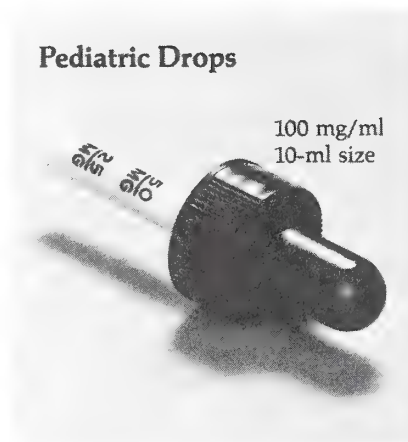
Gina DiBlasio Cummins is Editor of Synergy, and a staff writer for the Ohio State Medical Journal.



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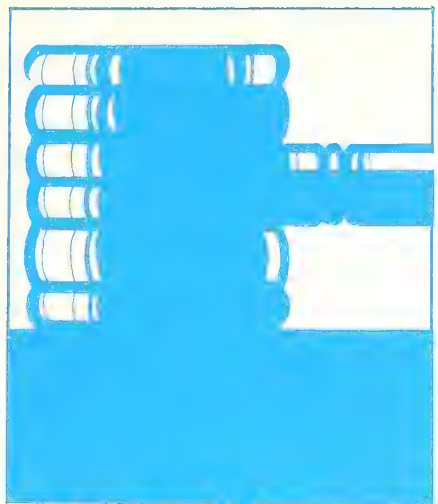


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council proceedings

April 16, 1983

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, April 16, 1983, at the Hyatt Regency/Columbus, 350 North High Street, Columbus, Ohio.

Those present were: C. Douglass Ford, M.D., Toledo; S. Baird Pfahl, Jr., M.D., Sandusky; David A. Barr, M.D., Lima; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Edward G. Kilroy, M.D., Cleveland; J. James Anderson, M.D., Youngstown; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; Frank Papay, Medical Student Section, Tallmadge; James E. Pohlman, Esq., OSMA Legal Counsel, Columbus; John H. Budd, M.D., AMA Past President, Cleveland; Oscar W. Clarke, M.D., Chmn., Member, AMA Delegation, Gallipolis; W. J. Lewis, M.D., Member, AMA Board of Trustees, Dayton; Rose Vesper, President, OSMA Auxiliary, New Richmond; Theodore J. Castele, M.D., Member, Ohio Delegation to AMA, Cleveland; William Dorner, Jr., M.D., member, Ohio Delegation to AMA, Akron; John J. Gaughan, M.D., member, Ohio Delegation to AMA, Elyria; Robert N. Smith, M.D., Member, Ohio Delegation to AMA, Toledo; A. Robert Davies, M.D., Member, Ohio Delegation to AMA, Troy; Edward E. Grable, M.D., Member, Ohio Delegation to AMA, Canton; Joseph Sudimack, Jr., M.D.,

Member, Ohio Delegation to AMA, Warren; Alan Mong, Medical Student Section, Columbus.

Those present from the OSMA Staff were: Hart F. Page, CAE, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, D. Brent Mulgrew, Esq., Rebecca J. Doll, Gail E. Dodson, Robert E. Holcomb, David C. Torrens, Carol W. Mullinax, Eric Burkland, Michael L. Bateson, Louis N. Saslaw, Catherine M. Costello, Esq., William E. Fry, Aristotle Hutras.

Announcements by President Ford

Dr. Ford called the meeting to order and welcomed Alan Mong, new Councilor for the Medical Student Section. On behalf of the Council, he thanked Frank Papay for his service in that position during the past year.

Administration

The minutes of the February 5 and March 20, 1983 meetings of the Council *were approved*.

Mr. Page presented the Executive Director's report.

In compliance with Section 4, Chapter 5 of the OSMA Bylaws, the following Councilors reported that their caucuses will nominate them as candidates for re-election in their respective districts: Drs. Abromowitz, Reed, Anderson, Spragg and Kloss.

The Executive Director read a telegram from Dr. Sammons with regard to the fact that Federal District Judge Gesell, in Washington D.C., ruled April 14 that the Department of Health and Human Services acted improperly in promulgating its March 7, 1983 rule regarding discrimination against handicapped infants. It was indicated that the Department will appeal the decision.

The Council asked that a copy of the minutes of the March 20, 1983 emergency meeting be sent to the Scioto County Medical Society in reply to the Society's letter of March 9, 1983, and that these minutes be sent to other county medical societies who have addressed the Council on the Medicaid statement of February 1983.

A letter from the Academy of Medicine of Cleveland to the Governor officially endorsing Leonard L.

Lovshin, M.D. for reappointment to the Ohio State Medical Board was presented to Council.

The Council authorized the President of the OSMA to file with the Governor, a letter indicating OSMA support for Dr. Lovshin's reappointment.

Letters of acknowledgement from Robert A. Lang, Ph.D., Executive Director of the Academy of Medicine of Cleveland, and Rose Vesper, President of the OSMA Auxiliary, were read to the Council.

Medical Students and Residents

Mr. Saslaw reviewed the February 19, 1983 annual meeting of the Medical Student Section for the information of the Council.

OSMA Education and Research Foundation

The OSMA Education and Research Foundation was discussed.

Dr. Ford recommended and the Council *approved*, the election of the following persons to the Board of Directors: Dr. Oscar W. Clarke, Chairman; Dr. Herman I. Abromowitz; Mrs. Rose Vesper; Dr. Perry R. Ayres; and Mr. Hart F. Page.

Financial and Membership Department

Mr. Gillen presented Financial and Membership statistics.

Dr. Barr presented the Treasurer's Report and it was accepted.

The Department report was presented in writing and was received for information.

Committee on Membership

Mr. Gillen presented the minutes of the March 30, 1983 meeting of the Committee on Membership.

The minutes *were approved*.

Department of Education & Meeting Management

Mrs. Dodson presented the report of the Department of Education and Meeting Management.

Committee on Education

The minutes of the March 2, 1983

continued on next page

Council Proceedings

continued

meeting of the Committee on Education were presented and filed.

1983 Resolutions

The Council reviewed the resolutions to be considered by the 1983 OSMA House of Delegates.

Department of Government Relations

Mr. Gillen presented the report of the Department of Government Relations in writing. It was approved.

Committee on Cost Effectiveness

Mr. Fry presented the minutes of the January 31, 1983 meeting of the Committee on Cost Effectiveness. They were approved.

Physicians Administrative Corporation of Ohio (PACO)

The minutes of the February 5, 1983 meeting of the PACO Shareholders were filed.

Ad Hoc Committee on OSMA's Role in Peer Review

Dr. Leech presented the minutes of the February 23, 1983 meeting of the Ad Hoc Committee on OSMA's Role in Peer Review.

The recommendation of the Committee that the Association posture itself to make a positive response to the Professional Review Organization under PL 97-248 was extensively discussed.

The recommendation was approved. (Dr. Anderson dissenting)

Committee on School Health

The minutes of the February 23, 1983 meeting of the Committee on School Health were presented by Mr. Clinger.

The Council approved the following recommendations of the Committee:

1. That OSMA support the concept of mandatory mumps immunization for Ohio school children.
2. That two physicians, one from the Committee on School Health and one from the Committee on

Mental Health, be appointed by the President to represent OSMA on the Child Abuse and Neglect Subcommittee, Ohio Chapter, American Academy of Pediatrics.

3. That OSMA recommend that local school districts consider the K-6 alcohol education program offered by the American Automobile Association — and that the following organizations be encouraged to consider the program: Ohio Association of school nurses; State Planning Committee for Health Education in Ohio; Ohio Congress of Parent-Teacher Associations.

The minutes as a whole were accepted.

Committee on Impaired Physicians

The minutes of the February 27, 1983 meeting of the Committee on Impaired Physicians were filed.

OSMA/ONA Liaison Committee

Activities of the OSMA/ONA Liaison Committee were reviewed by Mr. Clinger.

The Council adopted a substitute for the March 19, 1983 recommendations of the physician members of the OSMA/ONA Liaison Committee, asking that the staff investigate feasibility of and suggest guidelines for the concept of an award for outstanding bedside nurses in Ohio.

Department of Staff Counsel

Mr. Mulgrew discussed 1982 tax amendments involving HCFA, prospective payment of hospital charges, and Diagnostic Related Groups (DRGs) and the adoption of the prospective payment plan by Congress in March.

He also discussed Federal Trade Commission and Health Planning proposals.

Committee on Maternal & Neonatal Health

Mr. Gillen presented the minutes of the February 27, 1983 meeting of the Committee on Maternal & Neonatal Health.

The Council approved the following recommendations.

1. That legislation be introduced to amend section 3701.50 of the Ohio Code to require the mandatory gonorrhea culture to be taken at the onset of labor rather than at the first visit of the pregnant woman to the physician.
 2. That a study be made of the issue of physician reimbursement in those situations where someone other than the physician bills for the service and where such service is required to be provided under the "direction" and "supervision" of the physician.
- The minutes as a whole were accepted.

Department of Organizational Services

The report of the Department of Organizational Services was presented in writing and was reviewed by Mr. Campbell.

The report was filed.

Physicians Insurance Company of Ohio (PICO)

The Council authorized Dr. Pfahl or Dr. Ford or Dr. Payne to vote Class B Shares held by OSMA at the PICO Annual Shareholders meeting on May 15, 1983.

American Medical Association

The Council approved the actions of the April 14, 1983 organization meeting of Ohio's AMA Delegation and the election of the following officers: Dr. Oscar W. Clarke, Chairman of the Delegation; and Dr. Robert N. Smith, Vice Chairman of the Delegation.

Dr. Clarke and Dr. Lewis reported on AMA Delegation activities.

Department of Health Education

Mr. Clinger reviewed the written report of the Department of Health Education.

The report was filed.

Administrative Agency Relations

Ms. Costello reviewed the Health Lawyers Meeting on medical care cost containment in Medicare and Medicaid.

A review of the litigation brought by

the Ohio Hospital Association and the Ohio Nursing Home Association versus the Ohio Welfare Department was presented by Ms. Costello.

Ms. Costello announced that the concerns of the Council regarding the limited maternity rule were addressed by the Ohio Public Health Council in the adopted version of the rule.

The AMA statement on fluoridation was discussed by the Council and the following action resulted: The OSMA Council endorses the position of fluoridation adopted by the American Medical Association's House of Delegates in December 1974. The AMA policy position is as follows:

"The AMA considers the fluoridation of public water supplies at the recommended rate (0.7 to 1.2 ppm according to locality) to be a desirable and safe health measure for the total population and urges all communities to adopt the necessary measures."

This is a reaffirmation of prior policy.

Ms. Costello was authorized to write a letter to the Ohio Department of Health communicating Council's endorsement of the AMA fluoridation policy.

Department of State Legislation

Mr. Burkland presented the minutes of the March 30, 1983 meeting of the Committee on State Legislation.

The following proposals were discussed and actions on the bill by the Council are indicated.

HB 29 — *Licensure of Radiation Sources*: ACTION: Support.

HB 132 — *Licensure of Medical Radiation Technologists*: ACTION: Returned to Committee for further evaluation and recommendations.

HB 157 — *Registration of Home Health Agencies*: ACTION: Passive Support.

HB 176 — *Physical Therapy Board Revisions*: ACTION: Passive Support, on the condition that no substantive amendments are added to the bill.

HB 162 — *Blood Donor* (to permit 17-year-olds to donate blood without parental consent): ACTION: Passive Support.

continued on next page

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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC: National Academy of Sciences, 1980, p. 13.

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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General.* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient.* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage, one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets — bottles of 100.



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Council Proceedings

continued

SB 19 — EMT/Epinephrine (requires training and permits EMTs to administer epinephrine): ACTION: Support.

Coalitions for 21 — (an organization whose purpose is to raise the legal drinking age in Ohio to 21): ACTION: Defer action until such time as the issue is on the state ballot.

Handgun Control — ACTION: No position.

HB 181 — Chiropractic Team Physicians: ACTION: Strongly oppose.

HB 205 — Social Work Licensure:

ACTION: No position.

HB 220 — Adult Day Care Centers (regulation and licensing of): ACTION: No position.

HB 172 Standard Claim Forms: ACTION: Support.

Gonorrhea Cultures — (To amend Section 3701.50 of ORC to require that the mandated culture for gonorrhea for pregnant women be conducted at onset of labor rather than on first visit to the physician): ACTION: Support.

Prescription Abuse Data Synthesis — (Proposal developed by the AMA to assist state agencies in coordinating efforts to control drug diversion): ACTION: Direct legislative staff to explore with appropriate state officials the possibility of bringing the program into Ohio.

HB 208 — Expands Definition of Practice of Pharmacy: ACTION: Oppose.

Department of Communications

Ms. Doll announced several speaker training seminars.

The work of the Journal Advisory Committee was discussed and it was indicated that the structure is functioning well.

New publications were discussed and new departments in the *Journal*.

Department of Marketing & Field Services

The report of the Department of Marketing and Field Service was presented in writing.

Mr. Holcomb announces plans for visits of candidates to the caucuses.

continued on page 539

OSMA Impaired Physician Chairman Dies Suddenly

PERRY R. AYRES, M.D., Columbus, died suddenly May 28. He was 66. Dr. Ayers served as Consulting Medical Editor of the OSMA Journal from 1959-1974 and had served as chairman of the OSMA Impaired Physician Program for the past six years.

A vigorous and outspoken proponent of programs aimed at rehabilitating the impaired professional, Dr. Ayres was considered a national expert on the subject and had delivered over 60 lectures throughout this country and in England on the topics of drug and mental impairment, alcoholism and stress management among professionals.

The author of numerous articles on those subjects, Dr. Ayres was a speaker at three national conferences on the impaired physician, sponsored by the American Medical Association. He served as a consultant to several other state medical associations, including Massachusetts, Indiana, Rhode Island and West Virginia and consulted with hospitals and other professional associations in Ohio to help establish impaired professional programs. In 1983, he received the first Arthur Dobkin Fellowship in Chemical Dependency from the Summit County Medical Society.



Perry R. Ayres, M.D.

Dr. Ayres received his medical degree in 1942 from Western Reserve University and was in the private practice of internal medicine and cardiology. He was a clinical professor of medicine and preventive medicine at The Ohio State University College of Medicine and a staff internist and counselor on substance abuse at the Harding Hospital in Columbus.

Dr. Ayres is survived by his wife, Helene and three daughters. The family has requested that contributions be made to the Perry R. Ayres Memorial Fund in care of the Ohio State Medical Association, 600 S. High St., Columbus, Ohio 43215.

For additional information regarding the Memorial Fund, contact Lou Saslaw, 614/228-6971.

RAYMOND W. ALVIS, M.D., Sidney; Northwestern University Medical School, 1930; age 81; died February 4, 1983; member OSMA and AMA.

JOSEPH ARDAY, M.D., Cleveland; University of Praha, Czechoslovakia, 1930; age 80; died March 30, 1983; member OSMA and AMA.

SHAWKI S. ASMAR, M.D., Cleveland; Faculty Medical Damascus University, Damascus, Syria, 1957; age 57; died March 19, 1983; member OSMA and AMA.

OTTO W. BLUM, M.D., Dixon, Illinois; College of Medicine of Pecs, Hungary, 1927; age 82; died February 12, 1983; member OSMA and AMA.

LELAND E. CAMPBELL, M.D., Deltona, Florida; St. Louis University School of Medicine, 1940; age 70; died March 15, 1983; member OSMA.

ANTHONY H. DINDIA, M.D., Cleveland; St. Louis University School of Medicine, 1936; age 74; died May 8, 1983; member OSMA and AMA.

JOHN H. HESS, M.D., Ft. Myers, Florida; Case Western Reserve University School of Medicine, 1927; age 82; died April 3, 1983; member OSMA and AMA.

JAMES JANNEY, M.D., Bowling Green; Wayne State University School of Medicine, 1937; age 71; died May 2, 1983; member OSMA and AMA.

NICHOLAS M. KATONA, M.D., Cincinnati; State University of New York College of Medicine, Brooklyn, 1937; age 69; died May 6, 1983; member OSMA and AMA.

ALEXANDER KOROSI, M.D., Cleveland; Universitat Wien, Wien, Austria, 1930; age 78; died April 12, 1983; member OSMA and AMA.

MILTON J. MacKAY, M.D., Pittsburgh, Pennsylvania; State University of New York College of Medicine, 1945; age 63; died April 28, 1983; member OSMA and AMA.

JANE P. McCOLLOUGH, M.D., Cleveland; Case Western Reserve University School of Medicine, 1945; age 63; died February 13, 1983; member OSMA and AMA.

WYNNE SILBERNAGEL, M.D., Columbus; Jefferson Medical College, Thomas Jefferson University, 1930; age

77; died May 6, 1983; member OSMA and AMA.

EMERALD SPENCER, M.D., Cleveland; Howard University College of Medicine, 1935; age 88; died May 11, 1983; member OSMA.

HOMER T. YODER, M.D., Cleveland; Case Western Reserve University School of Medicine, 1943; age 64; died April 21, 1983; member OSMA and AMA.



Agency Reference

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James E. Masten, Wooster

WOOD

Mari B. Mulholland, Toledo

Council Proceedings

continued

Councilor Reports

The Councilors reported on activities in their respective districts.

General Counsel's Report

Mr. Pohlman presented the General Counsel's report.

He discussed the status of litigation regarding the OSMA/PICO group liability policy.

Mr. Pohlman also discussed the status of the Advance Plan litigation in Stark County.

OSMA Auxiliary

Mrs. Vesper reviewed her report which was presented in writing.

Dr. Ford thanked Mrs. Vesper for her attendance at Council meetings during the past year and for her excellent contributions to the Council deliberations.

New Business

Medicaid Problems

Dr. Irons discussed the Medicaid problem and the factors which must be dealt with by the Task Force which has been assigned to find solutions.

ATTEST: Hart F. Page, CAE
Executive Director

Coming in August

Drugs and the Human Factor. A Second Look.

Is there a problem with prescription drug abuse? If so, how extensive is the problem in Ohio? And what's being done about it? The August *Journal* takes an in-depth look at these questions . . . and provides some surprising answers.

THE EXPERTS AGREE...

ZYLOPRIM[®] (allopurinol) IS SIMPLE, EFFECTIVE GOUT THERAPY

Unlike uricosuric agents, Zyloprim[®] (allopurinol) is clearly the choice for:

OVERPRODUCERS/ UNDEREXCRETORS

"One recent suggestion is that overproducers of uric acid are more 'appropriately' treated with allopurinol and underexcretors with uricosuric drugs. Such an argument is superficially attractive but may be specious: most patients with gout... may nevertheless be managed perfectly well with allopurinol."¹

—G. Boss, MD et al

TOPHI, CALCULI, RENAL DISEASE

"... (1) patients with extensive tophaceous disease...; (2) patients with a history of renal calculi... since a uricosuric drug may exacerbate renal stone disease; and (3) patients with significant renal disease... who are unlikely to respond to a uricosuric drug."²

—Edward W. Holmes, Jr, MD

For information on adverse reactions, warnings, etc, please see brief summary of prescribing information below.

ZYLOPRIM[®] (allopurinol)
100 and 300 mg Scored Tablets

INDICATIONS AND USE: This is **not** an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim[®] (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION.

In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been

observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Occasional cases of hypersensitivity have been reported in patients with renal compromise receiving thiazides and Zyloprim concurrently. For this reason, in this clinical setting, such combination should be administered with caution.

In patients receiving Purinethol[®] (mercaptopurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age:

Zyloprim should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully

"The most important therapeutic measure is the administration of a drug which will block urate synthesis. The agent available at present is allopurinol (Zyloprim...) which is very effective and of low toxicity."³

—Alfred Jay Bollet, MD

"... allopurinol treatment appears to retard the progression of renal dysfunction."⁴

—T. Gibson, MD et al

LOW INCIDENCE OF TOXICITY

"Clinical experience with allopurinol suggests that most patients tolerate this drug well—a finding strongly supported by our data. Undesired or unintended effects of therapy were reported in only 1.8% of 1835 consecutive recipients."⁵

—G. T. McInnes, MD

1. Boss G, et al, quoted by Scott JT: Long-term management of gout and hyperuricemia. *Brit Med J* 281:1164, 1980.

2. Holmes EW Jr: A rational approach to gout. *Drug Therapy* 11:117-124, 1981.

3. Bollet AJ: Prevention and treatment of urate nephropathy and uric acid stones. *Resident & Staff Physician* 28:57-64s, 1982.

4. Gibson T, Highton J, Potter C, et al: Renal impairment and gout. *Ann Rheum Dis* 39:417-423, 1980.

5. McInnes GT, Lawson DH, Jick H: Acute adverse reactions attributed to allopurinol in hospitalised patients. *Ann Rheum Dis* 40:245-249, 1981.

observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects. Mild reticulocytosis has appeared in some patients.

Periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported. The incidence of skin rash may be increased in the presence of renal disorders.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

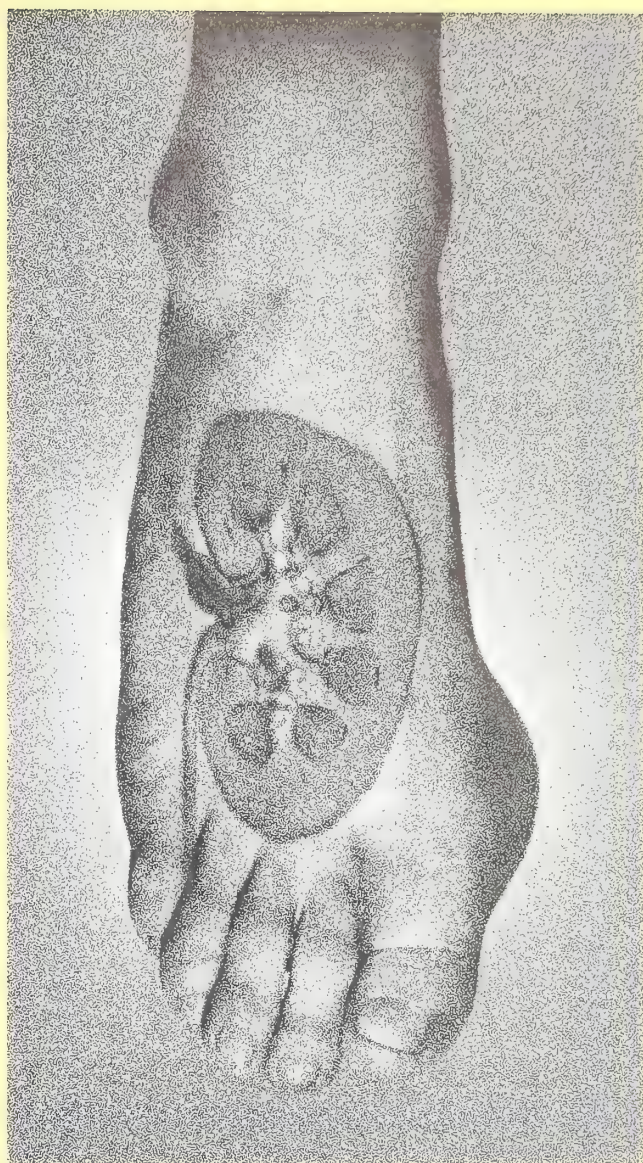
A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Hepatic: Rare cases of granulomatous hepatitis and hepatic necrosis have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim has been neither implicated nor excluded as a cause of these reactions.

Renal: Rare cases of renal failure have been reported in hypertensive patients who received thiazides and Zyloprim concurrently. Some patients had evidence of hypersensitivity to allopurinol.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yu for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

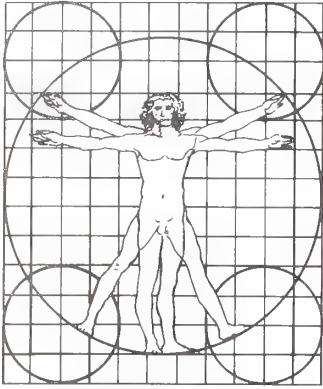
Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)



CLINICAL & SCIENTIFIC

USE OF THE HICKMAN CATHETER FOR CHRONIC VENOUS ACCESS

Bonnie L. Beaver, M.D.
Chris Regan, R.N.
Peter J. Fabri, M.D.

Hickman right atrial catheters have been placed to provide chronic venous access for diagnostic or therapeutic procedures in 18 patients (16 oncologic and two nononcologic). Mean duration of catheterization has been 117 days, with no incidence of systemic sepsis and only one local wound infection. Two catheters required replacement because of malfunction or malposition. Insertion of this permanent silastic catheter has provided a route for infusions or venous sampling with little morbidity or risk of infection to the patient.

THE USE OF PERMANENT indwelling silastic catheters (Hickman) has been reported in adults^{1,2} as well as children,³ and acceptance of the use of these catheters in patients requiring long-term venous access is increasing. Primarily recognized for providing access for prolonged parenteral nutrition,⁴ the Broviac catheter was modified in 1975 by Hickman, enlarging the lumen to facilitate blood collection.

We describe our initial six months of experience with Hickman catheter placement. To implement current chemotherapeutic techniques and to facilitate repeated intravenous peripheral therapy or phlebotomy, the Hickman catheter has proved to provide an appropriate access. The cephalic vein, when it is available, is most suitable as a channel for insertion. Patency of the vein is assessed preoperatively by bilateral upper extremity radionuclide venogram to exclude any occlusion of the axillary subclavian vena cava system. With patency demonstrated,

catheter placement is undertaken. The incision, a modified approach to the deltopectoral groove⁵ permits access to both cephalic and axillary venous systems. The catheter, advanced to the superior vena cava-right atrial junction and its position confirmed by Hypaque contrast injection under fluoroscopy,¹ is tunneled subcutaneously to an exit point on the anterior chest wall predetermined by the patient. Catheters were used immediately after insertion and maintained when not in use by heparin flush.

Patients and Methods

Catheters were placed in 18 inpatients on the hematology/oncology and surgical services of The Ohio State University Hospitals, who ranged in age from 16 to 66 years, with an average of 36 years. There were 7 men and 11 women. Diagnoses included: Hodgkins lymphoma (6), non-Hodgkins lymphoma (3), ovarian carcinoma (2), pancreatic fistula (1), Ewing's sarcoma (1), lymphosarcoma (1), meningomyelocele (1), and cholecystitis (1). The indication for Hickman catheter placement was the need for chronic venous access for chemotherapy and phlebotomy.

Catheter insertion was accomplished intraoperatively via the axillary vein (8), saphenous vein (3), or cephalic vein (7), with subcutaneous tunneling to a predetermined exit site on the anterior chest wall in all patients.⁵ Catheter position was confirmed by injection of undiluted Hypaque contrast under fluoroscopic surveillance. Catheters were used immediately after insertion: 2 cc of heparin flush (1,000 U/cc) was instilled when the catheter was not in use.

Results

During the period from June to December 1980, 20 Hickman catheters were placed in 18 patients; 15 were placed for chemotherapy delivery and phlebotomy, and three for venous access, with two patients each requiring one catheter replacement. Catheters remained in place for a mean of 117 days. One patient's catheter was removed before discharge, but the re-

Dr. Beaver, Columbus, Fourth Year Resident in General Surgery and Clinical Instructor, The Ohio State University College of Medicine.

Ms. Chris Regan, Reynoldsburg, Nutrition Support Nurse and Protocol Nurse, Ohio State University Hospitals.

Dr. Fabri, Worthington, Assistant Professor of Surgery, and Attending Staff, Ohio State University Hospitals; Associate Staff, Grant Hospital.

Submitted July 31, 1981.

maining 17 patients were discharged with a catheter in place after receiving instruction in catheter care.

There was no incidence of catheter-induced systemic sepsis. Local cutaneous infection occurred at the exit site on the anterior chest wall in only one patient and was satisfactorily treated with oral antibiotics. Three patients were treated successfully with streptokinase for catheter clotting. There was no incidence of venous thrombosis. Mechanical complications of catheter placement included malposition because of a defective Dacron cuff in one patient, and inability to withdraw blood via the catheter in a second, both necessitating catheter replacement. Follow-up through March 31, 1981, showed that nine patients are living, and eight died of their primary disease.

Discussion

In 1970, Scribner, et al,⁶ conceived and implemented the artificial gut for long-term parenteral nutrition in malnourished patients as an A-V shunt system. However, the arteriovenous shunt was short-lived as a circulatory access route primarily because of catheter clotting and infection.

Prolonged venous catheterization was employed safely by Wilmore and Dudrick⁷ via a superior vena cava catheter inserted through the subclavian or external jugular vein. Meticulous technic and catheter care in 30 consecutive placements in 25 adult hospital patients for an average of 24 days produced no incidence of catheter sepsis, phlebitis, thrombosis, or embolism.

In 1973, Broviac, et al,⁴ reported a technic using large central veins as a means of long-term or permanent circulatory access in ambulatory patients with minimal incidence of catheter sepsis (9%), technical difficulties including clotting (4%), and catheter malposition or malfunction (13%). The indwelling cuffed silastic catheter required minimum care and provided convenience and patient comfort with a minimal risk of infection.

Later, in 1975, Hickman modified the Broviac catheter by increasing the internal diameter from the former 0.22 millimeters to 0.32 millimeters. The larger bore permitted infusion as well as withdrawal of blood. A series of 75 marrow transplant recipients requiring infusion of blood, medications, and hyperalimentation, blood drawing and plasmapheresis was reported with an overall incidence of septicemia of 38%.¹

Patients can be divided into two groups according to the primary need for silastic catheters. One group comprises those in whom Hickman catheters must be used for infusion of blood products and medication including chemotherapy in addition to phlebotomy. The other group, candidates for long-term parenteral nutrition, require only the Broviac catheter, as it is smaller in caliber and less likely to result in venous damage.^{2,4} Our patients were in the former group.

Use of the Hickman catheter in pediatric oncologic patients³ and marrow transplant recipients¹ has been reported not to cause increased incidence of infection over previous methods.

Catheter-related sepsis and clotting with catheter malfunction, though infrequent, merit consideration. Septicemia, without a detectable focus, requires immediate culture of both blood and catheter samples, followed by administration of an appropriate antibiotic. Inability to identify a focus and continued sepsis despite antibiotics mandates catheter removal.

Exit site infections usually caused by *Staphylococcus epidermidis* can be treated successfully with appropriate antibiotics and local wound care, resulting in catheter salvage.

As the number of patients requiring indwelling silastic catheters increases, episodes of catheter malfunction related to clotting may occur. At the University of Washington Hospitals,⁸ once the presence of clot has been established by nucleotide dye catheter study and the use of heparin has been unsuccessful, 250,000 units of streptokinase dissolved in 2 cc of diluent is instilled into the catheter for two hours. Dec clotting occurs with blood return. After two hours, the streptokinase is aspirated from the catheter and the catheter flushed with 2.5 cc of 1,000 U/ml solution of heparin. Allergic reactions and fever are the most frequent adverse reactions, and the possibility remains of severe bleeding requiring aminocaproic acid and transfusion.

Once the catheter is in correct position, the patients are instructed on care as follows: (1) daily heparin flush (2 cc 1,000 U/cc) when catheter is not in use; (2) proper protective dressing over cutaneous exit site; (3) avoidance of direct contact with water. Periodic follow-up visits are scheduled in the outpatient clinic.

The patients report that the catheter's presence imposes no limitation on daily activities and, with care, no inconvenience. Painful phlebotomy and intravenous catheter insertion for chemotherapy are avoided. The indwelling Hickman catheter can provide mobility and comfort to the patient, without increased risk of infection.^{2,5}

Summary

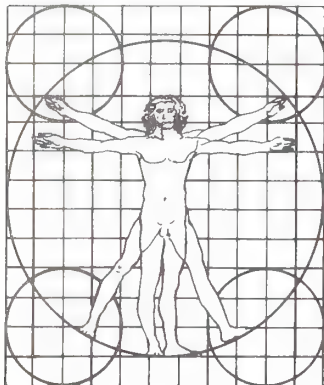
Our preliminary experience with placement of the Hickman catheter in patients requiring long-term venous access has been successful. The benefits of the use of the permanent silastic catheter were:

- (1) an increase in patient comfort;
- (2) the decreased need for venipuncture and peripheral venous catheters for inpatients and outpatients; and
- (3) a decreased risk of morbidity for the patients.

No incident of catheter-related systemic sepsis occurred in these 18 patients. Only one instance of local infection (5%) was observed.

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CLINICAL & SCIENTIFIC

GENITAL CLEAR CELL ADENOCARCINOMA IN YOUNG WOMEN IN OHIO

George A. Johnston, Jr., M.D.

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Walter Hull, M.D.

Harvey A. Jones, M.D.

In 1971, the initially reported association of clear cell genital cancer to prenatal exposure to Diethylstilbestrol was published. The Registry was established at the Massachusetts General Hospital to examine these extremely rare cancers in young women. Of the 429 cases currently in the Registry, collected worldwide, 12 cases are registered from the State of Ohio. A profile of these 12 patients is presented and the profile is generally similar to patient profiles in the entire Registry. Technics of screening DES-exposed patients are discussed.

IN 1971, HERBST, ET AL, reported seven cases of clear cell adenocarcinoma in young women treated at the Massachusetts General Hospital. Six of these patients had positive histories of prenatal exposure to Diethylstilbestrol (DES).¹ This same year a Registry was established to study the critical epidemiologic and pathologic aspects of this disease. At present the Registry accessions cases of clear cell carcinoma of the cervix and vagina in patients born in 1940 or after, with positive or negative histories of prenatal exposure to DES. In addition the Registry accessions other genital cancers in patients with definite histories of prenatal exposure.² As of June 1980, 429 cases have been accessioned in the Registry.³

No one knows exactly how many pregnant patients were given DES nationally or in the State of Ohio. It has been estimated nationwide that DES may have been given to as many

as two million patients during pregnancy. One can reasonably assume, from regional sales data, that there is a large population of DES-exposed patients in Ohio. The purpose of this article is to update the Ohio practitioner on the status of the cases of clear cell adenocarcinoma from Ohio currently accessioned in the Registry for Research on Hormonal Transplacental Carcinogenesis.

Materials and Methods

Cases submitted to the Registry are carefully reviewed with all available patient records carefully analyzed. The pathology and cytology are analyzed by Professor Robert Scully and his staff at the Homer Wright Pathology Laboratory of the Massachusetts General Hospital, Boston, Massachusetts. When appropriately validated, all information is indexed on a computer for data analysis and retrieval and information storage. All identifying information such as patient name, number, physician's name, and hospital name remain confidential.

The staging classification used by the Registry is the currently accepted clinical International Federation of Gynecology and Obstetrics (FIGO) classification for staging of cervix and vaginal cancer.

Results

Of the 423-plus cases currently in the Registry, 12 cases are reported to have lived in Ohio at the time of their diagnosis (see Table 1). Eight cases were reported from cities and towns in the northern part of the State of Ohio; four patients were from central Ohio and none reported from the southern region of the State (see Table 2). The patients' ages ranged from 11 to 27.5 with the median age being 18.7.

Maternal History

Seven of these patients have positive histories of prenatal exposure to DES or other nonsteroidal estrogen and two others

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Submitted October 14, 1981.

TABLE 1
GENITAL CLEAR CELL ADENOCARCINOMA CASES FROM OHIO

Case Number	Age	Maternal History	State	Treatment	Status
1	16.5	+ Unknown Substance	I	Radical Hysterectomy + Vaginectomy	NED
2	21	+ DES	I	Local resection	NED
3	11	+ DES	I	Radiation Therapy	Died at 24 mo.
4	30	- DES	I	local resection	NED
5	16.6	+ Unknown Substance	I	Radical Hysterectomy + Vaginectomy	NED
6	18	+ DES	I	Vaginectomy	NED
7	16	+ DES	II	Radical Hysterectomy + Vaginectomy	Alive with disease
8	12	- DES	I	Radical Hysterectomy + Vaginectomy	NED
9	18	- DES	I	Radical Hysterectomy + Vaginectomy	Loss to follow 6 years NED
10	20	+ DES	II _A	Radical Hysterectomy + Vaginectomy	NED
11	18.5	+ DES	II _A	Radiation Therapy	NED
12	27	+ DES	I	Radical Hysterectomy + Vaginectomy	NED

have positive histories of being exposed to unknown medication. Three patients have negative histories of any prescribed medication during pregnancy (see Table 3).

The majority of the cases were early-stage cancer. Nine cases were Stage I cancers, two were Stage II and one was Stage III lesion. There were no Stage IV cancers in this subgroup.

Pathology

All cases were clear cell carcinomas and there were no squamous cancer cases. Of the four basic histologic varieties identified, five patients had well-differentiated tubulo-cystic varieties. Three patients had the combination pattern and four had a clear cell pattern.

Treatment

The treatment of these patients varied greatly because of the varieties of location of the treatment. Five Ohio cases were treated in Cleveland; five Ohio cases were treated in different institutions outside the State of Ohio; and the remaining two patients were treated in Dayton and Columbus (see Table 4).

The treatment was largely by surgery. Seven patients were treated with radical hysterectomy, pelvic lymphadenectomy with total or partial vaginectomies. Two other patients were treated conservatively with tumor excision or vaginectomy with uterine conservation. Two patients were treated with radical radiation therapy alone. No cases in this series had combined surgery with radiation therapy (see Table 5).

TABLE 2
CLEAR CELL
ADENOCARCINOMAS IN OHIO

Location at the time of diagnosis
Number

Northern Ohio

Cuyahoga Falls	1
Cleveland	2
Sheffield Lake	1
Warren	1
Orville	1
Mansfield	1
Talmadge	1
Total	8

Central Ohio

Osterander	1
Columbus	2
Springfield	1
Dayton	1
Total	4

Positive DES
Steroid Estrogen/
Progestin or both
Other Hormone (Thyroid)
Unknown Medication
Negative Histories
Unavailable Histories

TABLE 3
CLEAR CELL ADENOCARCINOMAS
MATERNAL HISTORIES

Entire Registry	Ohio Cases
243	7
9	0
2	0
36	2
99	3
40	0
429	12

TABLE 4
CLEAR CELL ADENOCARCINOMAS IN OHIO

LOCATION OF TREATMENT	NUMBER
Cleveland	5
Columbus	1
Dayton	1
New York (Brooklyn)	1
Boston	1
New York (Manhattan)	1
Minnesota	1
Ann Arbor (Michigan)	1
Total	12

TABLE 5
CLEAR CELL
ADENOCARCINOMA IN
OHIO

TREATMENT	NUMBER
Radical Surgery	5
Conservative Surgery	1
Radiation Therapy	1
Combination	1
Total	12

TABLE 6
CLEAR CELL CARCINOMAS
FOLLOW-UP STATUS

	General Registry	Ohio Cases
Living and well	297	10
Recurrence now living	12	0
Living with disease	12	1
Dead	79	1
	400	12

Follow-up

The follow-up fortunately revealed the vast majority of the patients were successfully treated. Nine patients are alive and current follow-up confirms that they are entirely free of disease; one patient was lost to follow-up after six years of being free of disease; one patient is alive with disease; and the youngest patient in this report (age 11) died of disease 24 months after the initial diagnosis was made (see Table 6).

Discussion

The statistical observations noted in this subpopulation generally are in accord with those noted in the entire Registry population. The median age for both groups is essentially the same, 18.5 versus 18.9. Approximately two thirds of the patients in this General Registry and the Ohio cases have positive histories of DES ingestion. The patient outcome is reflected by the stage of the disease, although other contributory histologic and clinical factors have been identified. Scully, et al, reported of the four histologic varieties, patients with the tubulocystic pathologic variety have better survival than those with the solid or mixed varieties. Age may also be a factor in patient survival. Patients in the General Registry younger than age 15 had poorer survival rate than those older than 19.⁵ The

only patient in the Ohio group that died of her disease was the youngest patient at age 11, and histologically her tumor was a combination pattern.

Since most of these Ohio cases were of early staged lesions, radical surgery has been the most commonly selected mode of therapy (see figure). This also has been noted in the General Registry population of early staged lesions.⁴

In view of the apparent large number of DES-exposed females in Ohio, it is most important for the practitioner to understand clearly the proper screening for this disease. Several recent Registry cases were diagnosed while apparently under physician surveillance.⁶ A Pap smear is generally a very meaningful screening tool, however, if there is vaginal adenosis present, a four-quadrant Pap smear (smearing separately each vaginal quadrant) should be obtained at the initial examination.⁷ Lugol staining in the method described by Herbst using one half strength iodine adequately stains glycogenated vaginal epithelium and clearly delineates areas of adenosis.⁸

Colposcopy may be of benefit in the evaluation of the regression patterns of adenosis, however, it may be of little benefit in screening of clear cell cancer. The single most important step in evaluation and screening for genital adenocarcinoma is a carefully performed pelvic examination. The entire vagina should be visualized and any nodules or irregularities palpated, even when the area is visibly normal, should be biopsied. Although none of the Ohio cases presented as such, several cases have been reported to have submucosal lesions with



Clear cell vaginal cancer is located on the anterior vaginal wall. This patient was treated surgically with radical hysterectomy and vaginectomy. The darkened areas on the vagina represent vaginal adenosis.

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totally negative Pap smears that could be diagnosed only by biopsy. Since clear cell adenocarcinoma is such a rare disorder, diagnoses cases are best referred to a cancer treatment center.

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By Carol Wright
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One of the best ways to do this is to provide them with health information. There is an appalling amount of exaggerated, misconstrued and just plain incorrect health information on the market today. When patients come to your office, why should you let them find out about health care from a magazine or talk show host? There are thousands of free or at-cost educational materials available from professional associations, government agencies and pharmaceutical companies. For example, your local office of the Arthritis Foundation has

available free of charge a series of pamphlets on both the different types of arthritis and on the types of medications used to treat it. Your local cancer society and heart association provide similar services. If you are a specialist, you may want to check with your specialty society.

There is an appalling amount of exaggerated, misconstrued and just plain incorrect health information on the market today. Should your patients find out about health care from a magazine or talk show host?

The OSMA has several types of patient education materials available. As a member you receive each month a copy of *Synergy*, our patient education newspaper. You may want to order additional copies for your waiting room. *Synergy* also is an excellent publication for your patients to subscribe to and receive at home. *Synergy* advertising placards are available for placement in your office.

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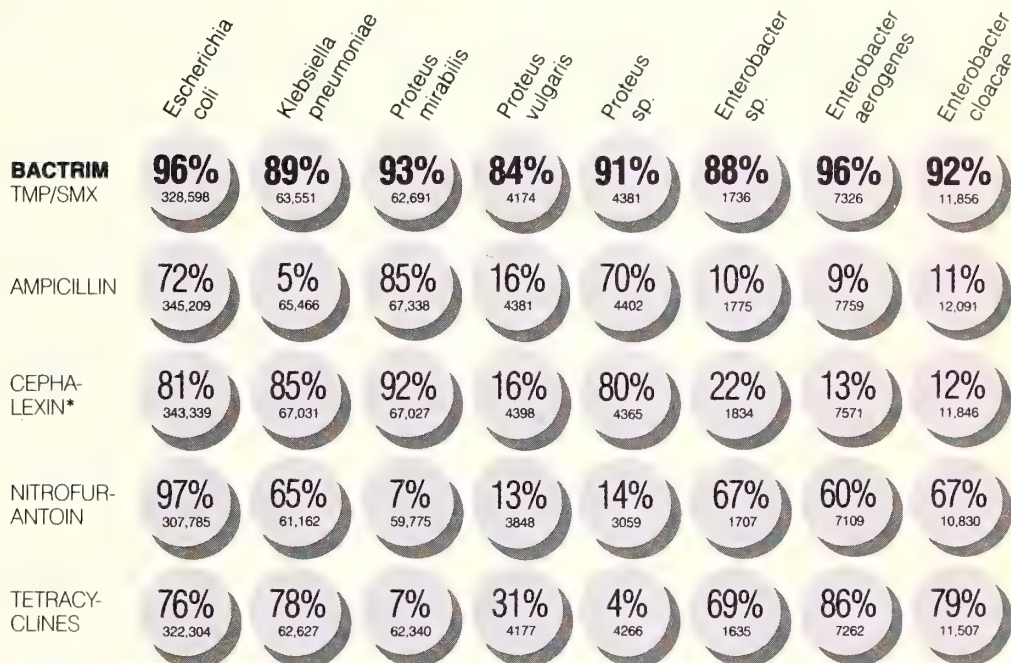
Once you have gathered all of the material, establish a patient education corner in your waiting room. If you make books available to your patients, set up an informal loan system so you are able to keep track of them.

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Carol Wright Mullinax is the Associate Director of the OSMA's Department of Communications

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References: 1. Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 2. Spicehandler J et al: *Rev Infect Dis* 4:562-565, Mar-Apr 1982. 3. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 4. Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 5. Cooper J, Brumfit W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. 6. Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. 7. Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. 8. Irvani A et al: *Antimicrob Agents Chemother* 19:598-604, Apr 1981. 9. Rous SN: *J Urol* 125: 228-229, Feb 1981. 10. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series 1976-82. 11. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980.

Bactrim™ DS (trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL

PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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From the Editor's Desk

Why a Second Look?

Two years ago, the *Journal* devoted an entire issue to the subject of "Drugs and the Human Factor." In that issue, we examined how very complex the subject of "drugs" becomes, once the physician, pharmacist and patient enter the picture.

Unfortunately, the picture has not cleared, nor become any less complex. The facts are the same. Drugs are, and probably always will be, medicine's most powerful ally in its fight against pain and suffering. With them, miracles have been accomplished. Children no longer die of diphtheria. Smallpox has been eradicated from the face of the earth. The crippling pain of arthritis and a myriad other diseases are lessened. Without them, humanity has touched the depths of despair.

And yet, their tremendous strength

and power can be abused — and have been abused by the human element. Ironically, the substances which have been created for man's good have been twisted, by man himself, to render harm.

Perhaps the most dangerous aspect of this situation lies in not recognizing that "the situation" exists. And perhaps the most dangerous aspect for physicians is in not fully comprehending that prescription drugs are and can be as dangerous in this situation as illicit drugs.

That's why the *Journal* decided to take another look at this subject. Prescription drugs are still a useful tool for the practicing physician, and yet, sadly, the fact remains that these drugs still are being abused, misused and misdirected.

Our responsibility is not to place

blame, nor point fingers, but rather to state the concerns and explore what is being done to reduce them.

The first section of this issue will explore the scope of the prescription drug abuse problem — nationally, and on a state wide level. In the second section, we will take a look at the types of actions and programs that are being initiated by the American Medical Association, the Ohio State Medical Association, and other drug-related agencies to help respond to the problem of prescription drug abuse.

Please read on. We hope you'll agree that the subject of "Drugs and the Human Factor" merits a second look. **OSMA**

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AVAILABLE: Bottles of 100, 500.

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Technocrat or Healer

By Robert J. White, M.D.

(reprinted from the AMA News, May 13, 1983)

Most people have presumed that physicians were a happy lot, busily administering to the ills of mankind, complaisant in the knowledge that theirs was a universally honored profession providing satisfaction and economic security. Now it seems that all is not well within or outside of our most distinguished profession.

Most concerning and potentially destructive to the very fabric of medical practice are recent criticisms leveled directly at physicians by special interest consumer groups, as well as from within the profession itself by certain medical commentators and educators. Collectively, these "experts" repeatedly are emphasizing their dissatisfaction with the American physician because they believe that he or she has become mesmerized by the new biotechnology and, in the process, has lost compassion for and appreciation of the individual patient and family. In other words, physicians now are characterized as technocrats without human feeling! What a sad and inappropriate commentary this is on the practice of medicine. How ironic it is, for only yesterday some of these same "experts" were telling us that physicians were not knowledgeable or interested in the introduction and application of advanced technology to diagnose and manage human disease.

What has happened? Nothing short of a true bio-revolution has occurred, concentrating into the hands of the practicing physician a pharmacological and instrumental biotechnology that not only allows him to diagnose with incredible accuracy and extend life, but even to cure many diseases that, only half a century ago, were incurable.

In spite of these advances in health care, articles are appearing with distressing frequency in the lay press and even learned medical journals emphasizing that the field of medical knowledge is so large today that it is difficult, at best, to acquire even a basic understanding of medicine. As a consequence, the physician, in attempting to remain intellectually conversant even within his own field, is sacrificing the emotional and social needs of his patients.

They further argue that insufficient time is being allotted to the humanistic and holistic requirements of medical practice. As this thesis has gained ascendancy, some of our best medical schools have begun to re-examine their curriculums to stress the emotional and social aspects of practice. Harvard, for example, is attempting to

pharmacology? Certainly not, for once again, we see an attempt to "socialize" American medical practice and even subvert its very educational process. In my opinion, this is misguided and misdirected. Certainly one has every reason to expect that a physician be concerned with and sympathetic to emotional requirements. What is far more important is that we need the absolute assurance that the physician is, first and foremost, thoroughly trained and experienced in contemporary medicine. Nothing would create greater anxiety among the public than the realization that a medical practitioner is not among the most skilled and knowledgeable of physicians.

In my judgment, one cannot teach sensitivity, humility, or compassion. These must and should be part of the

One has every reason to expect that a physician can be concerned with and sympathetic to emotional requirements, (but) what is far more important is that we need the absolute assurance that the physician is thoroughly trained and experienced in contemporary medicine.

design an experimental program that would emphasize the social and personal aspects of practice at the expense of the scientific aspects of medical knowledge.

Is all of this necessary? Has the individual patient been wronged as a result of these quantum advances in biomedical engineering and

intrinsic makeup of every physician and, therefore, become part of the selective process for medical school admission.

In the final analysis, the American public rapidly is becoming sophisticated in matters dealing with personal health and would, I believe,

continued on page 559

*"I can do things that I
couldn't do for 3 yrs. including
joining the human race again."*

*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procordia nor will they all respond to the same degree.



for the varied faces of angina

*Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA[®]
(NIFEDIPINE) Capsules 10 mg

Please see PROCARDIA brief summary on adjoining page.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: **General:** **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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continued

continue to prefer access to the best trained and most experienced physicians, rather than being looked after by a cadre of health gurus who emphasize verbal babble, herbs, and potions. **OSMA**

Dr. White is professor and cochairman of neurosurgery at Case Western Reserve U. and director of neurosurgery at Cleveland Metropolitan General Hospital.

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Rebecca J. Doll**

Bendectin withdrawn from market

Merrell Dow Pharmaceuticals announced plans to cease production of Bendectin, a drug used for more than 25 years for relief of nausea and vomiting during pregnancy, because of adverse publicity surrounding the drug due to several lawsuits and subsequent court rulings. A Washington, D.C., Superior Court jury recently awarded \$750,000 to the family of a girl born with birth defects after her mother took Bendectin.

The company strongly disputed the verdict, charging that Bendectin was "a victim of these litigious times" and that the verdict was "inconsistent with the overwhelming weight of scientific evidence that shows Bendectin is not associated with increase risk of birth defects."

Physicians having any questions regarding Bendectin should call 800/582-3109.

Upsurge seen in medical malpractice

Dramatic increases in the frequency and dollar volume of medical malpractice claims during the first half of the 1970s were due primarily to plaintiff trends in common law doctrine, according to a new Rand Corporation study. Although this was slowed during the next few years by tort reforms, physicians may see a new upsurge in claims if reforms now being challenged in the states' high courts are wiped out. (See report on recent Ohio Supreme Court ruling, page 609.)

Reforms being challenged include limiting the size of awards, informing juries of collateral sources such as medical insurance, and placing limits on contingency fees charged by attorneys.

Dr. Stephen J. Carroll, deputy director of Rand's Institute for Civil Justice, told *Medical World News*, "Reform legislation is being attacked, and in many cases successfully.

Doctors got organized and put legislation through, and now the pendulum, if you will, is moving back."

According to a report, "The Frequency and Severity of Medical Malpractice Claims":

- The number of claims grew from a mean of 2.76 per 100,000 population in 1970 to a mean of 10.04 in 1975 and fell back to 6.23 in 1978. Total claims dropped from 23,240 in 1975 to 17,238 in 1978.

- The dollar volume of claims, from 1975 to 1978, rose from a mean of \$19,793 in 1975 to a mean of \$36,766 in 1978.

The study found no evidence that an increase in the number of lawyers per capita during the 1970s significantly affected claim frequency, however, urbanization was cited as "the single most powerful predictor of claim frequency and severity."

Will health become an investment decision?

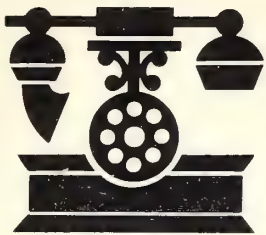
"Recent changes in medically-related legislation are important because they abandon the principle, in fact if not in rhetoric, that medical care should be provided whenever it is needed, that cost should not be considered when life or health is at stake," concludes a study by Louise Russell, economist with the Brookings Institution.

Medical expenditures are the fourth largest item in the federal budget and the cost of private health insurance, paid mostly by employers, is outpacing inflation, the study says. Simply put, cost no longer will be an objection even if health and life are at stake.

"Congress has implicitly agreed that some medical services have benefits that are too small or too costly to warrant the necessary expenditure," Ms. Russell said. She is convinced that

this will mean less heart surgery on the elderly for angina pain — they will be expected to live with it — less intensive care, less laboratory testing and fewer admissions of Medicare and Medicaid patients who need expensive care.

"Cost controls mean a decrease in quality. We support the system as it has been because it fulfills an emotional need that we have to do something in the face of serious illness and death. We won't decide to pull the plug at the patient's bedside. We just won't have the life-prolonging equipment there in the first place. It will be an investment decision. Finances will dictate who lives and who dies. But it will be very messy. There will be lots of court cases before we resolve it."



Organ transplant hotline

The first national hotline for organ transplants went into service in April and is being permanently staffed 24 hours a day at the University of Pittsburgh. Physicians and nurses can call the number for information such as whether a specific dying patient

800-24D-ONOR

would be suitable for organ donation, the nearest person in need of the organ and how an organ might be obtained. The service is sponsored by the North American Transplant Coordinators Organization.

The telephone number is 800/24D-ONOR.

How HMO salaries compare

All HMO physicians do not earn significantly less than their fee-for-service counterparts, but those directly employed by HMOs do earn considerably less than fee-for-service group practitioners, according to a report published in the American Journal of Public Health. According to study results, average income for HMO staffers was \$56,986 compared with \$74,179 for group fee-for-service physicians. "Even though our study shows that this salary discrepancy is generally not the case, the HMO recruitment problems could continue as long as this misconception persists," says Dr. Frederic D. Wolinsky, associate professor of hospital and health care administration at St. Louis University Medical Center.

New forms could reduce orders for lab tests

The annual cost of laboratory tests across the nation now is estimated at more than \$25 billion. Researchers from the University of Southern California School of Medicine, Los Angeles, suggest such costs could be cut substantially by rewriting the laboratory request form.

Researchers report a drop of 38% and 61% respectively in the ordering of triiodothyronine radioimmunoassay and thyrotropin tests, following a change in the request form covering thyroid function tests.

Test orders for creatine kinase isoenzyme and lactate dehydrogenase isoenzyme, thyroid function tests which were not altered in the request form "menu," remained substantially the same at 102% and 96% of baseline rates.

"The previous comprehensive

request form listed the four thyroid function tests. Perhaps because of doubt about how to make an appropriate choice, the user often ordered all four tests to avoid making a wrong choice," the authors say. "The problem-oriented test request form placed the thyroid tests into clinically useful groups or panels and assisted the user in obtaining the proper tests by naming the panels to indicate their clinical use."

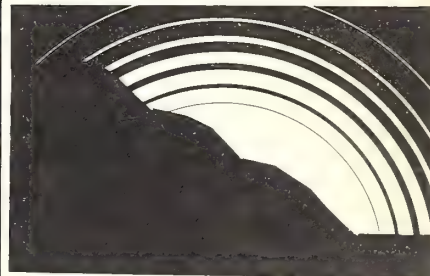
The study points out that previous attempts to alter laboratory ordering habits through educational programs were substantially ineffective. The strategy in the current program consisted of meetings with the medical staff and laboratory bulletins aimed at producing the results that finally were achieved by changing the "menu."

Allergy sufferers can breathe easier

A new antihistamine preparation may make it possible for some allergy patients to breathe easier while avoiding the sedative and other adverse effects associated with some antihistamine preparations. Clinical trials to date suggest there are no apparent contraindications for its use in adult allergy sufferers, nor have any carcinogenic, mutagenic or teratogenic effects been seen in animals.

Terfenadine, manufactured by Merrell Dow Pharmaceuticals, is an H_1 receptor antagonist — it specifically blocks the chain of cellular events following the release of histamine that triggers the typical symptoms of acute and perennial rhinitis and allergic dermatitis. However, it does not affect the CNS according to clinical trials.

Merrell Dow has marketed the drug in Canada, France, West Germany, the Netherlands, the United Kingdom, Switzerland and Belgium and has filed a New Drug Application with the U.S. FDA.



"Today" may solve tomorrow's problem

The FDA has approved a nonprescription, 24-hour vaginal contraceptive which can be inserted by hand over the cervix without physician assistance.

The device is a soft, disposable, polyurethane sponge permeated with a gram of spermicide nonoxynol-9, which is activated by moistening the sponge with water. Clinical trials show the sponge as having an 85% effectiveness rate, comparable to other vaginal contraceptives, including the diaphragm.

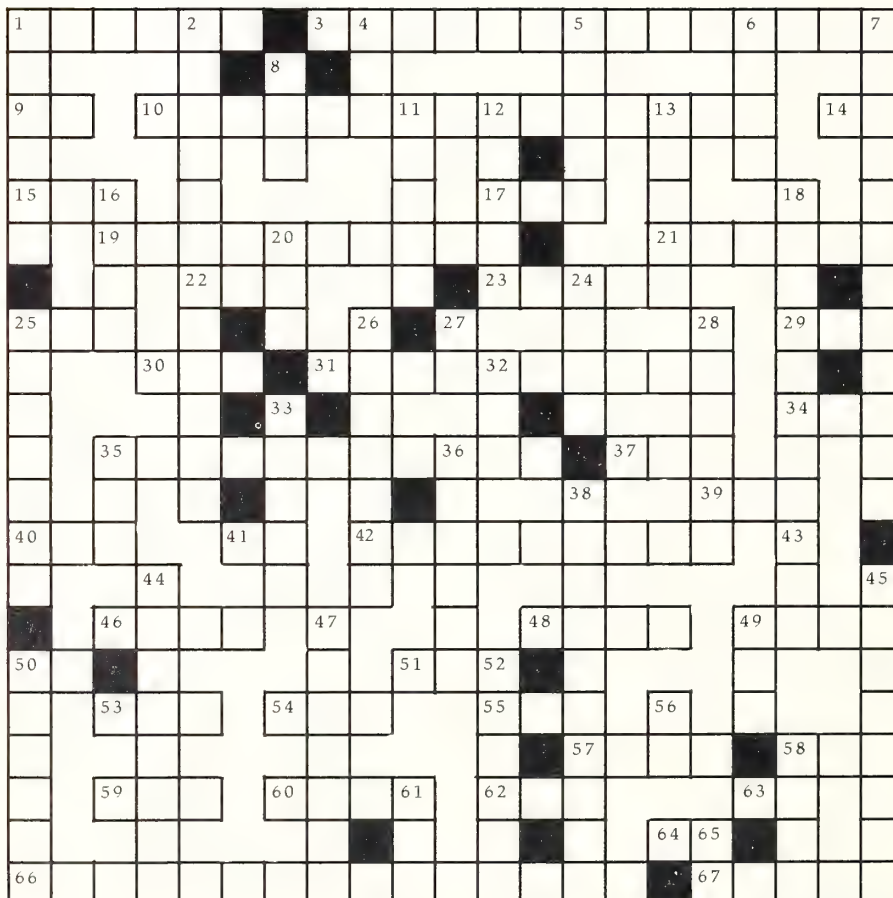
The sponge, which will be marketed under the name Today, will be available over the counter and could be in drugstores by late summer.

HYPERTHYROIDISM

By R.M. Benson, M.D.

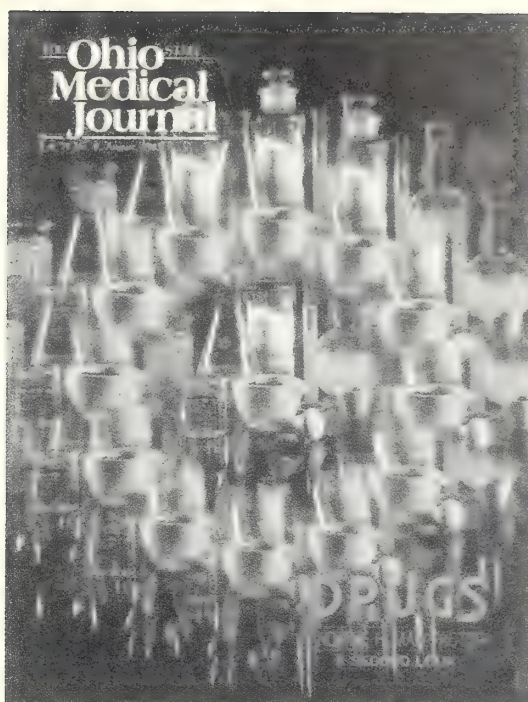
ACROSS: 1. Disease with hyperthyroidism and exophthalmos, 3. Disease of Excess thyroid hormone, 9. Parenteral fluid route (Abbr), 10. Radioactive iodine uptake phenomenon in hyperthyroidism, 14. Genetics of thyroid enzyme defects (Abbr), 15. Snake like fish, 17. Distress signal, 19. Consume, 20. Instantly, 21. Cornell's home, 22. Nodule associated with HT, 23. Palms in HT, 25. Long time period, 29. Irving to friends, 30. Pub order, 31. Etiology of HT, 34. Balloon filler, 35. Tissue producing TSH like substance, 37. Hematology value decreased by PTU, 39. Newt, 40. Drink cooler, 41. College degree, 42. RAI uptake in Graves Disease, 46. One type of eight down, 48. Remain, 49. Heavy metal, 50. Thus, 51. Pituitary hormone target of TRH, 53. LA footballer, 54. Crude metal, 55. Still, 57. Iodine isotope used to treat HT, 58. Male offspring, 59. TSH in HT, 60. Temperature intolerance in HT, 62. _____ Grande, 63. Where its _____, 64. To _____ or not to, 66. Thyrotoxicosis with an overactive thyroid, 67. Pulse in HT.

DOWN: 1. Enlarged thyroid gland, 2. Eye problem seen with Graves Disease, 4. Newborn congenital dislocation, 5. Desert water haven, 6. Baking chamber, 7. Thyroid producing ovary, 8. Immuno-globin producing Graves disease (abbr), 11. Its rapid in HT, 12. Soaking salts, 13. Sound over thyroid in HT, 16. Thin, 18. Iodine used to treat HT, 20. Drug used to treat HT, 24. Female name, 25. Misplaced thyroid, 26. Abscess, 27. Turner karyotype, 28. Dueled with an epee, 32. Govern. tax agency, 33. Rook and castle game, 35. Golf mound, 36. Ties, 38. Thyrotoxicosis with small thyroid and low RAI uptake, 43. _____ got a secret, 44. See twenty down, 45. Bone age in childhood HT, 47. A treatment of HT, 49. Place for experiments, 50. Skin in HT, 52. Half breed, 56. Thyrotoxicosis with normal thyroxine, 58. Halt, 61. Also, 65. Place where trauma is treated (Abr).



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Solution on page 638



Part I

The Problem: How Real Is It?

The abuse of illicit drugs has been a problem in this country for a long time. But, more recently, prescription drugs, the physician's tools and the source of so much good, have, themselves, begun to become a problem.

Why? How big a problem? And how great is the problem here in Ohio?

This section will take the problem of prescription drug abuse and examine it closely to determine both its existence and its scope.

For a national picture, we turn to a report recently issued by the General Accounting Office . . . but, for a look at the problem in our own state, we turn to the agencies which would know — the Ohio Board of Pharmacy and the Ohio State Medical Board.

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A leading pharmaceutical company speaks some

Words of Encouragement About Drugs

By David L. Reynolds

(Reprinted from *The Ohio State Medical Journal*, May, 1981)

In 1980 you and your colleagues put pen to paper 1.4 billion times to order for your patients one of the truly outstanding values of our time . . . the prescription drug.

Although drugs are still being abused and misused in today's society — problems which are addressed regularly in the professional and lay press — there are many positive aspects of pharmaceuticals that go virtually unnoticed. For example, life expectancy has increased from 47

Economic gains, too, have been enormous. It is estimated that the public benefited to the tune of \$57 billion between 1930-1975 by avoiding more expensive therapy and/or hospitalization.² Add to that the sums earned by those who otherwise would have lost wages due to illness, and the figure becomes almost incomprehensible.

To give a more digestible example, the British National Health Service recently estimated that effective

manufacturers' prices increased 42% during that period of time, while prices in general went up 117%.⁴ Prescription drugs account for little more than 5% of the total health care expenditure.

In 1960 it took patients an average of about two hours to earn the price of a prescription. In 1977 it took only about 50 minutes, making the medicinal products you prescribe an even better value today than they were in 1960.⁵

Unlike many industries, the developers of new prescription medicines finance their own research. Tax dollars are not used. Despite many obstacles and fewer incentives, the drug industry is spending \$1.5 to \$2 billion per year of their own money on research. Individual companies may invest up to \$60 million and ten years researching and developing a single new product. Many new and better treatments are waiting in the wings to be introduced in the United States. Some predict another "golden age" of new therapeutic entities that will render many of today's most reliable

continued on page 567

"Prescription drugs, with all of the problems to be overcome, may represent the best hope we have to contain health care costs."

years in 1900 to over 70 years in 1975. Although public health measures such as good sanitation and pure drinking water did much to improve life in the early 20th century, much of the improvement in life expectancy from 1930-1975 must be attributed to the fruits of biomedical research, primarily pharmaceuticals and biologicals.¹

treatment for the three disease categories of tuberculosis, mental illness, and chest disease saves more than the total payments by NHS to pharmaceutical vendors.³

Despite charges of profiteering at public expense, prescription price increases have been far below the consumer price index (1967-1979) for all goods and services. Pharmaceutical



Before and After

Before delivery, **Anusol® Ointment*** rapidly, temporarily relieves the itching, burning, and pain of hemorrhoids of pregnancy and other anorectal disorders. Used concomitantly, **Tucks® Pads** add cooling, soothing comfort to tender anorectal tissues. **Tucks** also serve as a hygienic rectal wipe, gently cleansing away potentially irritating fecal residue.

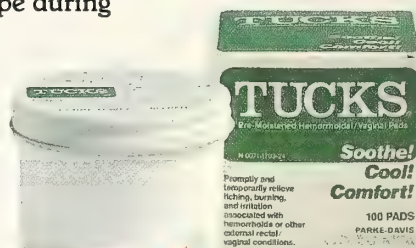
THEY WORK SO WELL TOGETHER!

*Anusol Ointment contains **PRAMOXINE HCl**—a non-"caine," topical anesthetic derived from morpholine and generally recognized as safe and effective for external use. Pramoxine is as potent as benzocaine but appears to be less sensitizing. Its distinct structure tends to minimize the risk of cross-sensitivity. Pramoxine acts within three to five minutes, and its anesthetic effect can last as long as several hours. In addition, Anusol Ointment contains emollient, lubricant, wound-healing, and protectant ingredients.

After delivery, **Anusol Ointment** and **Tucks Pads** work well together to maintain their complementary relief of postpartum hemorrhoids.

After episiotomy or other vaginal/rectal surgery, **Tucks** serve also as an ideal hygienic wipe or wet compress.

In nonpregnant women, **Tucks** are a useful vaginal wipe during menstruation or after napkin or tampon change.



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products obsolete. For diseases for which no treatment exists, a whole new world of chemotherapy will unfold.

Prescription drugs, with all of the problems to be overcome, may represent the best hope we have to contain health care costs. They are a direct, often measurable, effective, and even safe method of treating the conditions for which they are indicated. Nobody wants to be sick; nobody wants to pay to get well, but in terms of cost effectiveness the physician would be hard pressed to provide a better alternative to his patients except, perhaps, no treatment at all.

"Economic benefits are much more simple to quantify than the priceless commodities of comfort, peace of mind . . ."

We have talked about prolongation of life, but mostly we have talked about dollars. Economic benefits are much more simple to quantify than the priceless commodities of comfort, peace of mind, and a better "quality of life" in general. **OSMA**

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David L. Reynolds is Manager of Professional Communications for Burroughs-Wellcome Company, and is heard regularly on the Florida and Georgia Radio Network as host of "A Visit With Your Pharmacist," a drug information program for lay audiences.

Grim statistics reveal some encouraging facts about the nature of drugs

Table

Ten leading causes of death in the U.S., 1900 and 1975

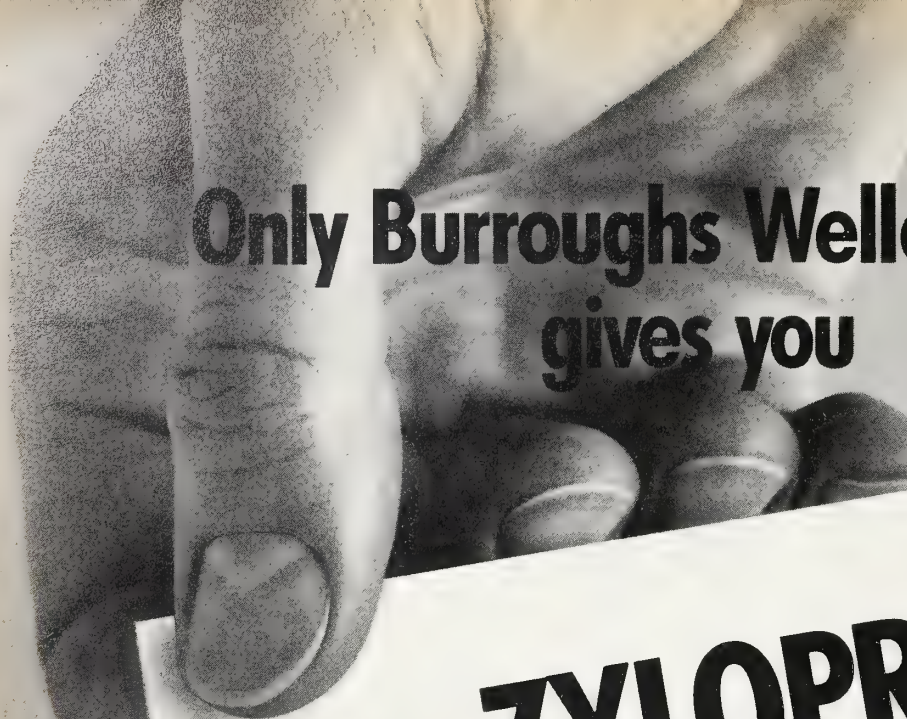
Cause of death	Rate of death (per 100,000 persons)
1900	
Influenza and pneumonia	202.2
Tuberculosis	194.4
Gastroenteritis	142.7
Diseases of the heart	137.4
Cerebral hemorrhages and vascular lesions affecting central nervous system	106.9
Chronic nephritis	81.0
All accidents	72.3
Cancer and other malignant neoplasms	64.0
Certain diseases of early infancy	62.6
Diphtheria	40.3
1975	
Diseases of the heart	338.6
Malignant neoplasms	174.4
Cerebrovascular diseases	91.1
All accidents	46.9
Influenza and pneumonia	26.3
Diabetes mellitus	16.8
Cirrhosis of the liver	15.0
Arteriosclerosis	13.7
Certain diseases of early infancy	12.5
Suicide	12.4

Source: National Center for Health Statistics.

Decline in the death rate from selected diseases following the introduction of pharmaceuticals, 1958 to 1974

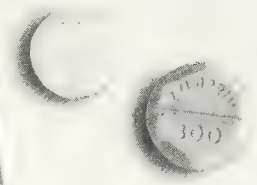
Disease entity	Percent decline	Type of pharmaceutical
Poliomyelitis	100	Vaccines
Whooping cough	100	Vaccines
Hypertensive heart disease	92	Antihypertensives
Tuberculosis	75	Antibiotics
Dysentery	50	Antibiotics
Appendicitis	64	Antibiotics
Asthma	69	Corticosteroids
Meningitis	46	Antibiotics
Syphilis	95	Antibiotics
Maternal deaths	67	Antibiotics
Nephritis and nephrosis	46	Antibiotics
Infant deaths	67	Antibiotics

Source: National Center for Health Statistics.



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The Problem . . .

A National Look

Editor's Note: To take a national look at the Prescription Drug Abuse problem, we turned to a Congressional report prepared by the United States General Accounting Office late last year. The report, entitled "Comprehensive

Approach Needed to Help Control Prescription Drug Abuse," not only defines the scope of the problem in this country, but also mentions what steps may be necessary in the future to help alleviate it.

Prescription drug abuse has been a widespread problem in this country for years, although not as well recognized as the abuse of heroin, cocaine, marijuana, and other illegal drugs. Prescription drugs such as stimulants, sedatives, tranquilizers, and analgesics have wide application and an important place in the practice of medicine. These drugs also have potential for abuse, and can cause great harm when used for nonmedical purposes. The health hazards are illustrated by national drug abuse statistics which identify prescription drugs in drug-related deaths and emergency medical situations more often than all illegal drugs combined.

Regulating prescription drugs to prevent their diversion for nonmedical use is a tremendous task. Approximately 20,000 drug products are controlled under Federal law, and over 20 billion dosage units of these products flow through the legitimate distribution chain each year. The drugs move from the manufacturer, to the wholesale distributor, to the retail outlet, and, finally, to the consumer. These legitimate channels of distribution involve over 625,000 registered manufacturers, distributors, and dispensers nationwide.

The abuse of prescription drugs has long been of concern to the Congress. Both the Senate and the House have

held numerous hearings on the topic. In 1970, the Congress passed the Controlled Substances Act to control the quantity of drugs available and, therefore, reduce their potential for abuse. In 1978, and again in 1979, the House Select Committee on Narcotics Abuse and Control held hearings on prescription drug abuse and concluded that these drugs were being both overprescribed by doctors and diverted into the illegal market.

ABUSE OF PRESCRIPTION DRUGS IS WIDESPREAD

Millions of Americans abuse prescription drugs, often with tragic results. A 1979 national survey sponsored by the National Institute on Drug Abuse (NIDA) showed that the nonmedical use of prescription drugs was second only to the use of marijuana/hashish.

No definitive statistics exist to show the amounts of abused prescription drugs coming from the various points in the legitimate drug distribution chain. However, indications are that most of the drugs are obtained at the retail (dispensing) level.

Diversion from the wholesale level (manufacturers and distributors) once was considered to be a major source of abused prescription drugs. However, the regulatory activities of DEA plus improvements in the

security and recordkeeping of drug inventories by manufacturers and distributors have significantly reduced opportunities for diversion from the wholesale level.

The retail level, on the other hand, has over 616,000 registered practitioners authorized to prescribe, administer, or dispense controlled drugs. DEA estimates that most — about 80 to 90% — abused prescription drugs coming from the legitimate domestic distribution chain are obtained at this level.

Supplied by the Drug Alert Warning Network (DAWN), statistics indicate that the retail level is the principal source of abused prescription drugs. For those cases reported by emergency rooms from March 1980 through April 1981, "legal prescription" was the predominant source identified — it was cited in 41% of the prescription drugs mentioned.

Controlling prescription drugs is the responsibility of both the federal and the state governments. Federal controls are focused at the wholesale level (manufacturers and distributors) of the legitimate distribution chain, while the states bear the primary responsibility for controlling the retail or dispensing level. The Controlled Substances Act defines federal responsibilities. The federal drug strategy for controlling

continued on next page

prescription drugs was developed on the basis of this law.

While the federal government has the authority to enforce criminal laws against those retail practitioners who illegally divert drugs from legitimate channels, it has limited statutory authority to regulate the retail level. Licensing, regulating, and monitoring this level have traditionally been state responsibilities.

Prescription drug abuse is more than a law enforcement problem, however. The numerous ways — both legally and illegally — by which abused prescription drugs are obtained make the control of this drug problem difficult and unique. Although opinions differ and virtually no reliable information exists on the relative size of the various means of obtaining prescription drugs, it is apparent that legally obtained drugs are involved in a major portion of the abuse which is occurring. However, the abuse of drugs properly obtained from legitimate channels is beyond the reach of law enforcement activities.

The difficulty often faced in securing felony convictions of practitioners who willfully divert drugs further limits what law enforcement can accomplish. Often it is difficult to obtain the necessary evidence required to prove a practitioner's criminal intent and gain a conviction. Therefore, prosecutors frequently refuse to prosecute these cases.

Pharmacies are required to keep detailed records of drugs acquired and dispensed. In regulating pharmacies, states examine these records to determine whether recordkeeping requirements have been adhered to and whether a pharmacist can account for all the drugs he or she dispensed. However, establishing criminal intent using records is difficult. Consequently, states generally use civil prosecution proceedings in pharmacy cases.

Physicians, on the other hand, keep fewer and less detailed records than pharmacists. Thus, proving willful diversion by a physician is even more difficult. Problems arise because of the gray area between legitimate and illegitimate practice. In diagnosing various illnesses and prescribing or dispensing the type and amount of

drugs for treatment, physicians necessarily have wide latitude in judgment. Proving that this judgment involves criminal intent is difficult.

Controlling prescription drug abuse requires that law enforcement agencies, regulatory boards, professional associations, and others work together to address the various legal and illegal sources of prescription drugs.

At a 1967 AMA conference attended by physicians and representatives of law enforcement and licensing agencies, there was general agreement that committees should be created at state and local levels to strengthen liaison among medical, law enforcement, and regulatory bodies so as to prevent and control the abuse of drugs. Conference attendees generally agreed that the principal functions of

federal, state and local government agencies in cooperation with professional education and trade organizations was repeatedly emphasized. States and concerned professionals must determine the type of program needed in light of their own circumstances, and that the federal government would do everything possible to encourage the establishment of adequate systems for monitoring and control.

In June 1981, the AMA adopted a report prepared by its special drug abuse panel which recognized that prescription drug abuse can result from both intentional and unintentional actions of physicians.

The AMA report recommended that state medical societies carry out the following specific actions:

1. To curtail prescription drug abuse

Prescription drug abuse is more than a law enforcement problem, however. The numerous ways — both legally and illegally — by which abused prescription drugs are obtained make the control of this drug problem difficult and unique.

such committees should include:

- **working with federal, state, and local law enforcement and judicial agencies and state licensing bodies to prevent misuse and abuse by physicians and to process, investigate, and adjudicate complaints;**
- **consulting with individual physicians on problems arising in their practices; and**
- **upgrading the skills and increasing the understanding of physicians in practice, physicians in training, and medical students with respect to narcotics abuse.**

In addition, the conference proposed that a national committee be created to establish principles of proper medical use of narcotics.

More recently, the White House Drug Policy Office sponsored a meeting in September 1979 to discuss possible courses of action to remedy the problem of diversion of prescription drugs to illicit use. The need for coordinated efforts involving

and to promote appropriate prescribing practices, these societies should institute a comprehensive statewide program that incorporates the following elements:

- a. Determination of the nature and extent of the prescription drug abuse problem.
- b. Cooperative relationships with law enforcement, regulatory agencies, pharmacists, and other professional groups to identify "script doctors"* and bring them to justice and to prevent other unlawful activities related to prescription drugs.
- c. Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved.
- d. Educational materials on appropriate prescribing of controlled drugs for all physicians and for medical students.

2. Recognizing the fact that even optimal prescribing practices will neither eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse, state medical societies should:

- a. Educate patients and the public on the appropriate medical uses of controlled drugs and the deleterious effects of the abuse of these substances.
- b. Provide instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

To help implement the recommendations, the National Steering Committee on Prescription Drug Abuse was formed. The members emphasized that only through a cooperative effort among the medical, pharmaceutical, and governmental organizations could these recommendations be carried out, and to that end uniformly pledged their support. The Committee has since taken steps toward achieving these recommendations. **OSMA**

*The AMA report defines "script doctors" as physicians who willfully, consciously, and usually for profit, misprescribe drugs for drug abuse purposes; "duped doctors" as physicians who inappropriately misprescribe drugs because they unwittingly acquiesce to the demands of patients for medication; and "dated doctors" as physicians who engage in uninformed prescribing because they have not kept abreast of new pharmacology and drug therapy developments.

Button batteries latest health hazard

Ingestion of disk-shaped "button" batteries used to power watches, cameras, calculators and hearing aids is becoming a significant health hazard, according to physicians writing in a recent issue of the *Journal of the American Medical Association*.

As many as 850 such ingestions occur annually, estimates Toby L. Litovitz, M.D., of Georgetown University Hospital in Washington, D.C. In a retrospective analysis of 56 cases, most involving children, he found five in which the batteries became impacted in the esophagus. Two of those patients died.

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The Problem . . . Across the Board

The Ohio Board of Pharmacy

By Carol Wright Mullinax

The question of whether or not Ohio has a prescription drug abuse problem is tantamount to asking if crime exists in the state. The answer is unfortunate, but realistic.

"Yes, we do have prescription drug abuse in Ohio," says Frank Wickham, and, as Director of the Ohio Board of Pharmacy, it's his job to know. Wickham is responsible for the safe distribution of drugs in Ohio. Any diversion which may occur in the route from manufacturer to patient is met with an immediate investigation — through his department, or through one of the other boards or law enforcement agencies which may need to be involved (see related Medical Board story).

"One of the biggest problems we see is the doctor who is duped," says Wickham. And that's not too surprising. After all, what chance does the busy health professional stand against a clever, criminal mind which is constantly devising ways to obtain drugs, legally or illegally?

"What we would like to see is better education along these lines for health professionals," Wickham continues. "A lot of problems with prescription drug abuse could be avoided if physicians were more aware of how slip-ups occur."

For example, he urges caution when physicians are dealing with patients who are strangers, or who request a drug by name. Both situations have the potential for abuse.

"And physicians should make certain that local pharmacies know who in their office has the authority to call in prescriptions." It's a simple safeguard that sometimes is overlooked. Another similar safeguard

**"A lot of problems
could be avoided if
physicians were
more aware of how
slip ups occur."**

dictates that care be taken to keep prescription pads, hypodermic needles and drugs safely out of sight.

However, there are occasions when it appears doubtful that a doctor has been duped — and that's when the investigative team steps into the picture.

The first step, according to Wickham, is for the team to contact the Medical Board and law

enforcement agencies to see if a similar complaint has been received. If it is determined that there may be a case, an investigator is sent to the area. It is his job to verify the information given to him by the Board, and to try to gauge the extent of the problem.

"We employ 12 office personnel and 11 field investigators to handle approximately 225 new cases a year," says Wickham. In addition to Board assignments, field investigators circulate among police departments and health professionals to gather information.

"Too, we log approximately 21,000 calls a year which may or may not point to the possibility of a case."

For the fact is, some cases are closed before they're even begun.

"The investigator may determine that there is no basis to the complaint, or that there is a problem, but it isn't criminal," Wickham says.

Sometimes the problem is simply poor recordkeeping.

"Physicians are not always the best recordkeepers," Wickham says.

But, if grounds for criminal action are discovered, then the information is turned over to the local prosecutor or the federal court.

"Our agency is not as concerned with those doctors who are being

duped, as we are with those who are knowingly and intentionally diverting drugs," Wickham explains.

And there are doctors in Ohio who are engaged in this kind of criminal activity. The percentage is not great — no greater than the number of Ohioans who are involved with crime — but the statistics and convictions are there as proof. In however small a number — they do exist.

"We've learned that it is usually a small percentage of physicians who are diverting a large number of drugs."

"We've learned that it is usually a small percentage of physicians who are diverting a large number of drugs," says Michael Bateson, OSMA's Assistant Director of State Legislation, and a member of the AMA's Steering Committee on Prescription Drug Abuse.

"For example," says Wickham, "in one case, recently tried here in Ohio, a doctor was convicted of selling 6,200 prescriptions in one eight-month period."

The case was unusual, but it serves as a strong backup to Bateson's statement.

The other problem which the Pharmacy Board occasionally has run into is the physician who abuses drugs. Recognizing the physician's susceptibility to this problem has prompted programs such as the OSMA's Physician Effectiveness Program which seeks to assist physicians who have alcohol and/or other drug-related problems.

"The trend has changed," says Wickham. "Where alcohol used to be the primary substance of abuse, now it's other drugs."

He indicates that the trend has become especially prevalent among younger physicians.

"We see cases at the intern level, but that's not too surprising," says Wickham, who conceded that the



Frank Wickham (right), Director of the Ohio Board of Pharmacy, confers with Jim Tudor, Chief Investigator for the Board

pressures and stresses of medical training often lie behind the abuse.

"As the abuse of prescription drugs becomes increasingly widespread, it becomes increasingly important for physicians to be aware of the situation, and to exercise caution when dealing with drugs," says Wickham.

It seems to be sage advice for physicians who are faced with the dilemma of balancing their patients' need for treatment against the potential of drug abuse. **OSMA**

Carol Wright Mullinax is the Associate Director, Department of Communications, and a contributing editor to the Journal.

The Ohio State Medical Board

By Gina DiBlasio Cummins

Elderly Doctor A complies with a teenager's demand for drugs when threatened with physical harm . . . Writing stacks of prescriptions and selling them to patients has supplemented Dr. B's practice substantially . . .

To save time, Dr. C keeps prescription pads in every examining room where they are easily accessible — maybe too accessible . . .

The circumstances may be different, but the outcome is the same — Doctors A, B, and C all have contributed to the abuse and misuse of drugs in some capacity. Unfortunately, practices such as these, unwittingly or not, are partially responsible for generating our country's drug abuse problem and explains how many prescription drugs are filtering down to our nation's streets.

There is no question that part of Ohio's drug abuse and misuse problem stems from the practices of some physicians and that the number of physicians involved has increased in recent years. "However, this increase is due largely to the better techniques used in uncovering these cases and is reflected by the increase in drug use by the public in general," says Oscar W. Clarke, M.D., president of the Ohio State Medical Board. "Since we are living in a 'drug culture' where we have a pill for every symptom, there has been a marked increase in physician drug abuse in Ohio compared to 30 years ago. However,

this increase is not disproportionate to the rest of society. It has occurred across the board."

"Even with the increase in drug misuse and abuse in Ohio, less than 5% of the physicians in Ohio cause 100% of the problem," claims William J. Lee, Esq., administrator of the Ohio State Medical Board. He notes that the drug misuse/abuse pattern occurs across the state; with a greater prevalence among the urban population, especially in areas where the younger population congregates. He notes that alcohol is the most frequently abused drug in all areas by all ages, closely followed by marijuana, amphetamines and amphetamine-like drugs, valium and quaaludes.

How do physicians become involved with the abuse and misuse of these and other drugs? "Everything centers around the four Ds — a doctor is usually either Disabled, Dated, Duped, and a smaller percentage, simply Dishonest," says Dr. Clarke. He explains that disabled physicians are doctors whose professional competence has been impaired by alcoholism, drug abuse, mental illness or deterioration from age. Dated physicians have not kept abreast of the developments in pharmacology or drug therapy. They are usually poor prescribers because they lack information or understanding. Duped physicians have ethical intentions but fall prey to identity misrepresentation of patients who are drug abusers or who wish to obtain drugs for sale to others. Dishonest physicians are motivated by

greed and prescribe purely for profit — not for medical indications.

In addition to these four areas, Dr. Clarke notes that a large number of cases fall into a fifth category, or fifth "D" — difficult to describe. "In these instances, a physician is not really ignorant, but also is not really aware of the effects of some of the drugs he is prescribing. Unfortunately, this awareness cannot be generated by simple continuing medical education. It can only evolve through knowing the background of one's patient, a good working knowledge of pharmacology, and knowing the community environment of a patient's life."

Once a physician becomes trapped into one of these categories where he establishes an abuse/misuse pattern, he or she is more easily brought to the attention of the Ohio State Medical Board. "Most of the tips we receive come from the hard data of our own investigating processes," notes Dr. Clarke. He adds that although the Board investigators do an excellent job of uncovering drug abusers, there are too few of them — only six in the entire state. "We really need at least 17 investigators to even approach the job of uncovering these cases." In addition to the information provided by the investigators, the Board also relies on the cooperation of federal and state agencies.

The first step the Board takes when it suspects a physician of wrongdoing, is to call the physician in for an "informal interview." "The most important function of this one-on-one

discussion between a physician and medical board member is to let the physician know that he/she is being monitored." During the course of the interview, a medical board member will discuss the physician's problem, explain ways in which to avoid a mistake, and channel him/her to specific areas of help.

"Guiding physicians to an appropriate area of help is a large part of our work," notes Dr. Clarke. "We are always trying to work with and encourage professional associations to develop impaired physician committees." He says that the Ohio State Medical Association (OSMA) has been very instrumental in

"Unfortunately, the entire problem of professional discipline is one of the most disappointing and frustrating problems we have. Since we operate within a system of law and all of our procedures must guard a person's individual rights, many disciplinary actions we take are appealed to a court of law. Our disciplinary action can be stayed by a court of law or our disciplinary procedure may be delayed for months and even years while the case is going through due legal process." He says that physicians and the general population find it difficult to understand why immediate and prompt action cannot be taken in every case. "The answer is because the

such as a teenager, obtain the prescription and use it for illegal purposes?

- Be aware of how the prescription is being used and carefully limit refills.
- Handle your prescription pad the way you handle your checkbook — very carefully.
- Make use of the duplicate prescription pad to guard against patients altering prescriptions.
- Do not preprint your DEA number on your prescription pad. Write it out each time as you do your signature.
- Be more suspicious of patient misrepresentation.

In addition to adopting these

The physician's awareness of the effects of some of the drugs he is prescribing can only evolve through knowing the background of one's patient, a good working knowledge of pharmacology, and knowing the community environment of a patient's life.



Oscar Clarke, M.D., President of the Ohio State Medical Board

establishing such a committee (see related article). "The OSMA has assisted in developing the impaired physician's committee to function as a support group, very similar to Alcoholics Anonymous. This is an extremely effective committee since the majority of the physicians offering support have lived through a similar crisis — and can empathize with the problem."

Dr. Clarke notes that if the physician in question does not show immediate response to the informal interview mechanism, they will be subject to stricter disciplinary measures. The Board can either suspend or revoke a license, or when necessary, incarcerate a physician.

Board MUST follow due process, the statutes of Ohio and the Constitution of the United States."

Since the Board can and will take strict disciplinary measures, physicians have a strong incentive to avoid a drug misuse or abuse problem. "In addition, the early education of physicians on the problem of drug abuse is another way to avoid a potential problem," notes Dr. Clarke. Besides urging medical schools to emphasize training young physicians in prescriptions and drug abuse, he offers the following guidelines for physicians already in practice:

- Always question your patient's background before filling out a prescription. Can someone at home,

guidelines, physicians should call the Ohio State Medical Board for additional advice and tips on safeguarding their medical practice from a potential drug abuse or misuse problem. By taking simple precautionary measures such as these and becoming increasingly aware of the existing drug abuse problem, Ohio physicians can monitor their own practices more effectively while simultaneously helping to restrict the number of prescription drugs which are reaching the streets of Ohio. OSMA

Gina DiBlasio Cummins is the Editor of Synergy, and a staff writer for the Journal.

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Part II

The Problem: What's Being Done?

Now that we've determined the existence of the problem, as well as its nature, we turn our attention to what is currently being done to help alleviate it.

The American Medical Association provides us with an overview of its programs — as well as one it's developing from an interesting experiment that took place in Wisconsin.

The Ohio State Medical Association is not far behind the AMA's efforts, however . . . and we take a look at just what the OSMA is doing to battle the problem of prescription drug abuse in our own state.

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The AMA . . .

Making Strides Toward a Remedy

By Joseph H. Skom, M.D.

The gravity of this nation's problem with drug abuse is now being widely reported. What is generally not sufficiently understood, however, is the extent to which misuse and abuse of prescription pharmaceuticals contributes to the overall drug abuse problem.

Nonetheless, the hazards involved in nonmedical use of prescription drugs are substantial. For example, data reported through the federal Drug Abuse Warning Network (DAWN) in 1981 show that prescription drugs were involved in about 60% of all drug-related emergency room visits and 70% of all drug-related deaths. While many of these drugs were channeled into nonmedical use through theft and diversion at the wholesale level, or were illegally manufactured or imported, a significant amount reached "the street" through dispensing on prescription. Therefore, greater caution in prescribing and dispensing controlled substances clearly is warranted.

Measures to counteract prescription drug misuse, abuse and diversion can take several approaches, including education, persuasion and legal control. Recognizing that physicians must have the greatest possible latitude in their use of drugs, the AMA has endorsed a series of general and specific guidelines issued in 1981 by the U.S. Drug Enforcement

Administration to encourage "acceptable professional responses to the demands of the Controlled Substances Act." The general guidelines affirm that controlled substances do have legitimate clinical usefulness, but that prescribing these drugs requires special caution because of their potential for abuse.

In the area of medical education on drug abuse, the AMA has made significant contributions. The 1970 monograph on *Drug Dependence* presented the best clinical information on drug abuse available at that time. Since then, the volume of research on the etiology, pharmacology and sociology of drug abuse has expanded at a rapid rate. Unfortunately, so has the proportion of the population — youthful and adult — that is experimenting with illicit drugs, or using them regularly. Indeed, physicians are seeing a growing number of patients whose medical and psychological problems are caused or complicated by drug abuse. At the same time, the scientific literature has become so rich and diverse as to require exhaustive and time-consuming study.

In response to this dilemma, the AMA has published *Drug Abuse*, a concise text for physicians that incorporates the latest research on, and clinical experience with, drug abuse.

In addition, in late 1982, AMA and the GTE Corporation unveiled a new nationwide telecommunications information system — the AMA Medical Information Network. This network will be able to transmit clinical, educational and socioeconomic information to physicians and other health care professionals. When completed, it will be the largest and most extensive system of its kind ever developed.

The AMA network is designed to help physicians keep pace with today's exponential growth of medical information. The initial service includes four data bases: Drug Information (based on the fifth edition of *AMA Drug Evaluations*), Disease Information, Medical Procedure Coding and Nomenclature, and Socioeconomic Bibliographic Information.

Using the Drug Information data base, physicians will have immediate access to current information developed by experts on drug actions and interactions, prescribing indications and cautions.

The AMA also continues to publish its major reference work, *Drug Evaluations*. This volume, now in its fifth edition, provides pharmacologic and comparative evaluations of more than 1,800 individual drug preparations under more than 5,000 trade names. The new edition features

an entire chapter on the special problems inherent in prescribing controlled drugs and the need for patient education on appropriate use of all prescription medications.

To assist the physician in that educational process, the AMA has developed written instructions for patients on the most widely prescribed drugs. The new program, called Patient Medication Instructions, or PMIs — is available to physicians for use in their counseling with patients. Use of the PMIs should enhance the effectiveness of therapy, reduce the risk of improper drug use, decrease the incidence of preventable and serious adverse reactions, and help patients comply with instructions for proper use of prescription medications.

In addition, the AMA Health Education Program is developing a series of one-page information sheets to respond to inquiries most often received from the public. These information sheets will cover topics of broad public concern, including treatment resources for drug and alcohol problems, correct use of prescription medications, and how to communicate effectively with one's physician about prescription drug effects and reactions.

COOPERATIVE EFFORTS

Cooperative efforts with other organizations are conducted through the AMA Informational Steering Committee on Prescription Drug Abuse. The Steering Committee convened in November 1981 in response to a charge from the AMA House of Delegates that called on AMA membership and staff to cooperate with all other interested organizations in developing effective programs to reduce prescription drug diversion and abuse.

The Steering Committee began its work by agreeing to:

- Foster the development of problem identification and resolution activities through cooperative, interdisciplinary programs at the state level.
- Develop methods to identify substandard prescribers and dispensers, to assess the causes of their problems, and to institute appropriate remedial measures.
- Promote better prescribing and dispensing practices on the part of

all practitioners.

- Educate patients and the public in the proper use of prescription drugs.
- Engage the support of all concerned professional and governmental organizations for cooperative programs to achieve these goals.

To achieve the goals, the committee set ten objectives:

Agreed to use the Steering Committee to arrive at agreements on the nature of the problem and what to do about it.

Supported a series of interdisciplinary conferences designed

how to use statistics now available for federal, state and local agencies to determine the extent of drug diversion within a state, the drugs involved, and the sources of those drugs (see related article).

Decided to study legislative issues that affect regulation, enforcement and intervention activities with prescribers and dispensers.

Agreed to explore the feasibility of national clearinghouses for use by state authorities in exchanging information about disciplinary actions against prescribers. Without such a clearinghouse function, it is all too

The AMA Medical Information Network will be able to transmit clinical, educational and socioeconomic information to physicians and other health care professionals. When completed, it will be the largest and most extensive system of its kind ever developed.

to initiate common understanding of problems and solutions at the state level.

Urged the formation, in each state, of an interdisciplinary task force to coordinate ongoing problem identification, goal-setting, planning and action.

Agreed to establish a financial clearinghouse to match the resource needs of state program planners with available sources of support.

Endorsed the development of longitudinal methods of instruction in prescribing for use in residency training programs, with the idea that this is the best way to reduce prescribing problems not just this year or next, but for many years to come. Work on a model program now is underway as a cooperative venture of the American Medical Association, the National Institute on Drug Abuse, and the Career Teachers in Alcohol and Drug Abuse.

Agreed to develop a data analysis model for use by states in identifying sources of diversion. This model — called Prescription Abuse Data Synthesis (PADS) — will demonstrate

easy for prescribers and dispensers whose licenses have been revoked in one state simply to relocate in a different jurisdiction.

Resolved to study the effects of multiple-copy prescription systems on diversion and the quality of patient care. In recent years, the value of triplicate and other multiple prescription systems has been hotly debated in several states. The proponents and opponents of such systems often point to the same body of data, which suggests that wherever these systems have been adopted, the number of prescriptions for covered drugs has fallen.

Resolved to improve the ability of physicians to diagnose and treat (or appropriately refer) patients who are dependent on drugs and alcohol. **OSMA**

Joseph Skom, M.D., is Associate Professor of Clinical Medicine, Northwestern University Medical School, and is the Chairman of the Informal Steering Committee on Prescription Drug Abuse, and of the AMA Panel on Drug Abuse.

Success Story

How Wisconsin handled its amphetamine abuse problem

By Darold A. Treffert, M.D. and David Joranson, MSSW

Reprinted from the Journal of the American Medical Association, April 3, 1981, Volume 245, Copyright 1981, American Medical Association.

Amphetamine abuse is a major component of the drug abuse problem in the United States.

In 1975, prescriptions numbering 25.4 million were written for amphetamines and related anorectic drugs. Manufacturers' sales totaled \$84.6 million and retail sales totaled \$170 million. The production of diet pills reached a total of 12 billion pills in 1971, most of them Schedule II substances. Interestingly, a large portion of amphetamines being sold in the streets are those legitimately manufactured and identified as coming from legal prescriptions (2.5 million Americans regularly use amphetamines) — outright diversion by health care professionals of legal drugs to illicit use (usually in the so-called fat clinics), or by theft from manufacturers, distributors, pharmacies, or practitioners themselves.

Yet, there is general medical consensus that the clinical usefulness of these products is exceedingly narrow and confined to only two relatively infrequently occurring conditions — narcolepsy and some forms of hyperkinesis in children. The medical profession, like the Food and Drug Administration, has concluded that the usefulness of amphetamines in weight control is at best "clinically trivial."

Hence, in the United States, there exists the incredible situation of 12

billion pills being prescribed when there are only two relatively rare conditions for which those products are clinically indicated. The majority of that vast quantity of products finds its way into the illicit market, where it contributes liberally to the drug abuse problem itself.

Until 1978, there was no exception to that problem in Wisconsin. It became increasingly apparent to drug treatment professionals, prosecutors, emergency room personnel, and the public itself that a sizable number of amphetamines legitimately manufactured and prescribed were being sold in the street. Many of these were coming directly from the so-called fat clinics in which prescriptions, and not services, were for sale. Indeed, some Medicaid recipients were obtaining prescriptions by seeing a physician, using their Medicaid card, having the prescription filled with Medicaid paying for the medication, and then selling those drugs at a considerable profit on the street. This became a lucrative business and for some a livelihood.

Methods

In March 1976, the Wisconsin Controlled Substances Board (CSB), of which Dr. Treffert is the chairman and Mr. Joranson is the staff person, learned of instances where several state physicians were purchasing large

quantities of amphetamine products. Since practitioners and pharmacies must be registered with the Drug Enforcement Administration (DEA), and since each Schedule II controlled substance purchase must occur on a triplicate order form, and since information on this form is programmed into the Automation of Reports of Consummated Orders System (ARCOS), the CSB decided to obtain specific but anonymous purchase data on the retail level (i.e., practitioners and pharmacies) to monitor the distribution and the use of Schedule II amphetamines in Wisconsin. The Board selected one amphetamine on which to request purchase data — the combination of dextroamphetamine and amphetamine (Biphedamine 20). This product was chosen because it had only two National Drug Code designations, was a manageable request on the first contact with ARCOS, and was widely available on the illicit market as "black cadillacs."

Working with the calendar 1975 data, the Board discovered that 26 of the approximately 9,500 licensed practitioners in Wisconsin had purchased a total of 118,300 doses of Biphedamine 20. Of the 26 practitioners, there were 20 physicians, three osteopaths, and two dentists and podiatrists. As few as five of the 26 practitioners accounted fully for 71%

continued on next page

of the 118,300 doses. Over 460 pharmacies in Wisconsin purchased a total of 798,200 doses of Biphedamine 20. This represented 44% of the licensed pharmacies in Wisconsin in 1975.

Less than 5% of all the pharmacies in Wisconsin accounted for nearly one-half of the total amount of Biphedamine 20 sold to all pharmacies in the state.

The Board shared its 1975 data on Biphedamine 20 with the medical, dental, and pharmacy examining boards with the request they determine the legitimacy of the activities of their licensees. Specifically, the CSB requested the Pharmacy Examining Board to determine from prescription records how many (or how few) practitioners were generating the prescription demand handled by the top pharmacies.

The Pharmacy Examining Board conducted a unique prescription audit on ten of the highest volume pharmacies in Milwaukee County. Pharmacy inspectors tallied up the number of Biphedamine 20 prescriptions according to the prescribing physician. Of the total 10,212 prescriptions (approximately 33.3 million doses), only eight practitioners had prescribed 87.7%.

In February 1977, the first of two new state policies concerning amphetamines was announced. The Department of Health and Social Services instituted a restriction on the reimbursement of Title XIX (Medical Assistance) claims for amphetamine products (unless previous authorization had been granted).

In June 1977, the CSB conducted an annual day-long symposium entitled "Diversion of Licit Controlled Substances." Participants included leaders from the medical, dental, and pharmacy licensing boards, the State Medical Society, State Department of Justice, Department of Health and Social Services, and the DEA. There was considerable media coverage. The CSB presented the amphetamine data and the Pharmacy Examining Board presented its amphetamine prescription audit on the ten Milwaukee County pharmacies. There was general agreement that the data described a pattern of prescription of

amphetamines for nonmedical purposes generally occurring under the guise of the treatment of obesity.

Following the symposium, the Medical Examining Board, on advice of the Peer Review Commission of the State Medical Society of Wisconsin, promulgated the following policy defining "as unprofessional conduct" the prescription or dispensing of amphetamines for any purpose other than five limited clinical indications and one research use: The treatment

Less than 5% of all the pharmacies in Wisconsin accounted for nearly one half of the total amount of Biphedamine 20 sold to all pharmacies in the state.

of narcolepsy; the treatment of hyperkinesia; treatment of drug-induced brain dysfunction; the differential diagnostic psychiatric evaluation of depression; the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the Board before such investigation has been begun.

Results

The new amphetamine policy took effect on November 1, 1977. The CSB with the cooperation of the DEA began monitoring impact. An average of 27,000 doses were sold monthly in 1976. In February 1977, sales dropped to 2,200 doses, apparently a direct effect of the Department of Health and Social Services' restriction on Title XIX reimbursement. After the CSB symposium in June, sales dropped again. When the unprofessional conduct rule took effect, sales dropped to 1,200 doses (12 bottles of 100 pills).

Sales continued to decrease to 800 doses in December and 700 in January 1978. A comparison of sales during the period of November through January 1978, with the average during the 12 months of 1976, shows a 97% decrease. To validate this trend, the Board monitored other products at other Wisconsin distributors, and similar trends were evident for the combination of dextroamphetamine sulfate and prochlorperazine maleate (Eskatrol) (an amphetamine) and phenmetrazine hydrochloride (Preludin), as well as Biphedamine 20.

Corresponding to this drastic drop in amphetamine sales, amphetamine-related arrests have dropped drastically in Milwaukee County alone (from 103 in 1976 to 23 in 1978), confirming the impression that curtailing supply is reflected in less criminal activity with respect to that particular product. There has been no corresponding increase, contrary to fears, in diversion or switch to Schedule III or IV stimulant-anorectics.

The DEA arrested two of the physicians partly responsible for generating the 10,202 prescriptions described in the pharmacy audit. They were subsequently convicted in federal court for unlawful distribution of a controlled substance without a legitimate medical purpose.

Comment

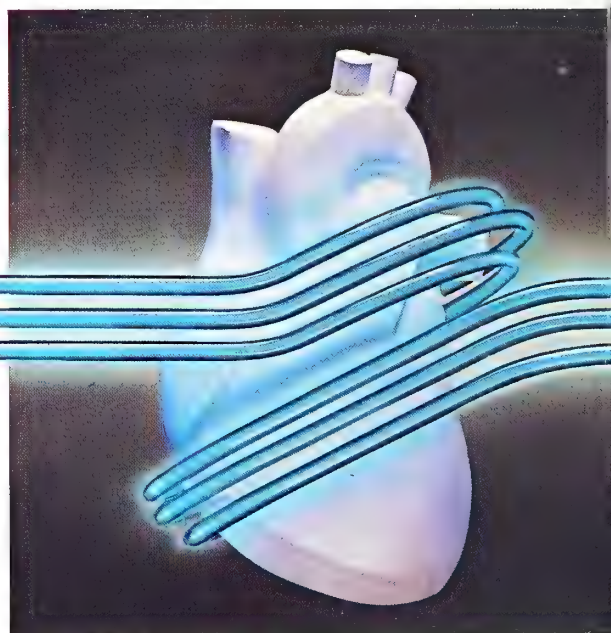
The new amphetamine policy in Wisconsin has appropriately scaled down amphetamine supply to meet legitimate medical need and, in so doing, has eliminated a small but important portion of the nation's demand for production. The CSB has requested that the DEA consider further reduction in future manufacturing quotas for amphetamine, methamphetamine hydrochloride, and phenmetrazine, and has supported the FDA's interest in eliminating the obesity indication for amphetamines.

This is the first time the DEA data has been used in this way. The ARCOS data can provide every state with information on every drug in Schedule II, including the amphetamines, barbiturates, methaqualone, and narcotics such as

continued on page 592

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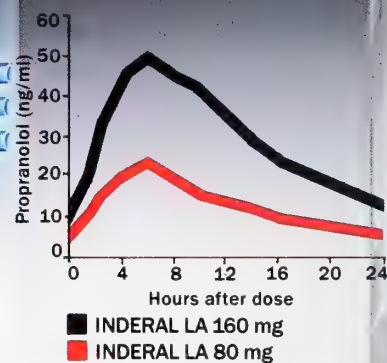
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ONCE-DAILY

INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

MEAN PLASMA LEVELS
ATTAINED WITH INDERAL LA
OVER 24 HOURS

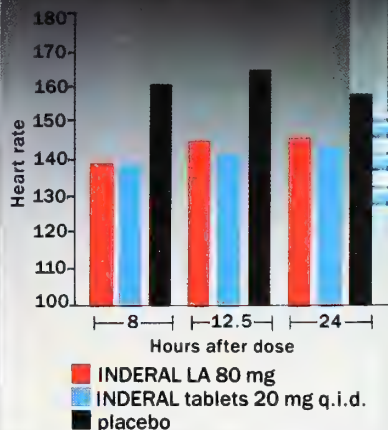


THE ONE
TO COUNT ON
FOR SMOOTH
PLASMA LEVELS—

Sustained plasma levels

In pharmacokinetic studies, blood levels with once-daily INDERAL LA were found to be adequate to maintain sustained clinical effect throughout 24 hours. The unique controlled-release formulation of INDERAL LA minimizes differences between peak and trough plasma concentrations.

EFFECT ON POST-EXERCISE HEART RATE OVER 24 HOURS*



AND 24-HOUR BETA BLOCKADE

Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose—with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



80 mg



120 mg



160 mg

The appearance of INDERAL LA capsules is a trademark of Ayerst Laboratories.

*INDERAL LA vs. tablets: N.S. at all hours measured.

*INDERAL LA vs. placebo: $p < .05$ at all hours measured.

Please see last page for Brief Summary of Prescribing Information.

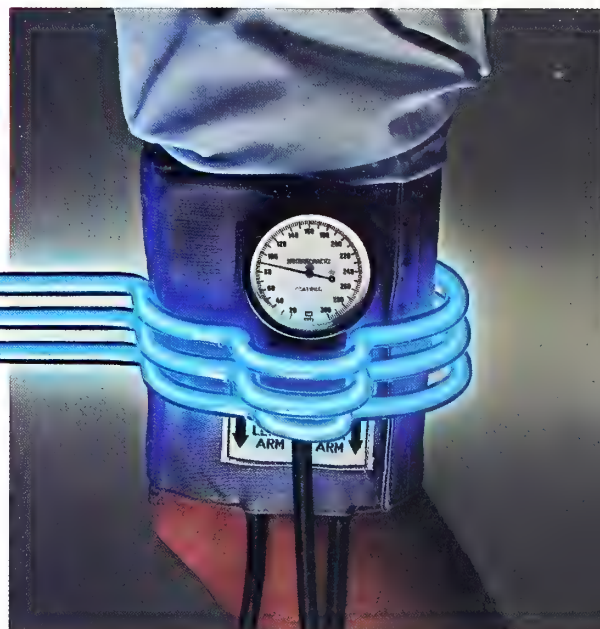
NEW

ONCE-DAILY

INDERAL[®] LA

(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

**THE ONE
TO COUNT ON
FOR INITIAL
THERAPY IN HYPERTENSION**



Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

**Unsurpassed convenience
and simplicity**

Enhanced patient compliance



THE
ONE
TO COUNT ON

AND ANGINA

**Simplified core therapy begins
with 80 mg once daily**

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

**Compatible with
other conventional antianginal
therapies**

**The experience and protection
of INDERAL**

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



80 mg

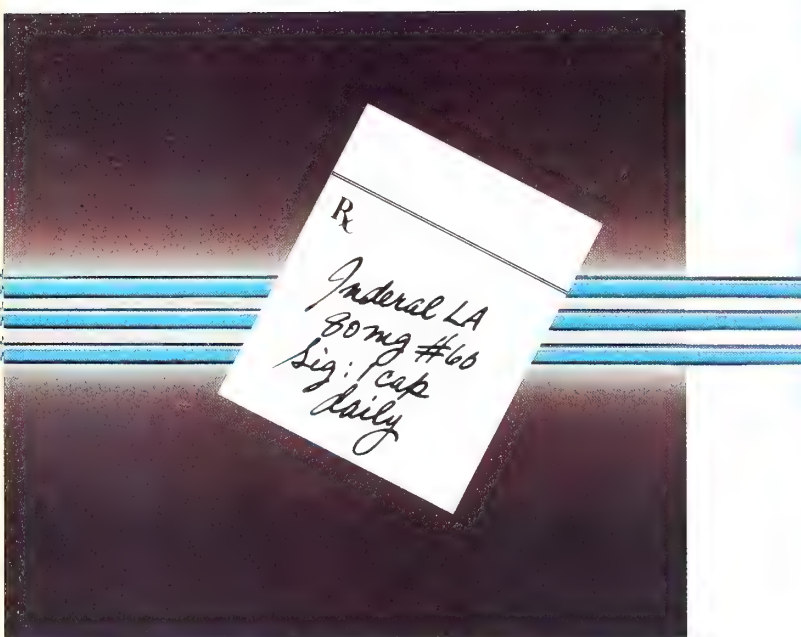


120 mg



160 mg

The appearance of INDERAL LA capsules is a trademark of Ayerst Laboratories.



THE
ONE
TO COUNT ON

**THE ONE TO
COUNT ON FOR
THE EXPERIENCE
OF INDERAL
NOW WITH ONCE-
DAILY DOSAGE**

In hypertension, angina, and
migraine— start with 80 mg
once daily

Smooth 24-hour control

Unsurpassed simplicity and
convenience

Enhanced patient compliance

Three strengths for prescribing
convenience

For arrhythmias, use
conventional INDERAL® tablets

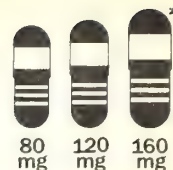
Ayerst®

AYERST LABORATORIES
New York, N.Y. 10017

Please see last page for Brief Summary of Prescribing Information.

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

ONCE-DAILY INDERAL[®] LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)
INDERAL[®] LA brand of propranolol hydrochloride

(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General. Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established. If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories. 8511/783

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Success Story

continued

meperidine (Demerol) hydrochloride and the combination drug containing oxycodone hydrochloride and terephthalate, caffeine, aspirin, and phenacetin (Percodan). It is an easy task to pinpoint suspected overprescription, and the data can be of assistance in understanding local drug abuse problems.

The ARCOS data, combined with the technique of computer cartography using zip code zones, provide a graphic technique for easily identifying problem areas in any state for any Schedule II substance. Using this same technique, the CSB already has been

It is an easy task to pinpoint suspected overprescription, and the data can be of assistance in understanding local drug-abuse problems.

able to identify a serious methaqualone diversion problem in one area of the state and a serious amobarbital sodium use problem in another portion of the state, both of which now have already been analyzed, and by education in one instance and prosecution in another, have been corrected. A statewide analysis of sedative-hypnotic use and diversion has been completed, which led to the amobarbital and methaqualone problems pointed out previously. A study of the Schedule II narcotics, including Percodan, is now under way. The computer cartography graphs are equally as striking for these problem areas as they were for the amphetamines. An extremely useful epidemiologic technique has emerged, in this case having to do with controlled substances, but the technique could be applied in many other inquiries into incidence and prevalence as well, graphically pointing out areas for immediate inquiry and explanation. **OSMA**

Ohio's Connection

The shortest route from Wisconsin to Ohio is via the American Medical Association . . . or such has been the case, anyway, with PADS — the Prescription Abuse Data Synthesis program which is modeled after a program developed by the Wisconsin Controlled Substances Board.

PADS was designed by the AMA as a coordinated approach by which data previously scattered among different agencies could be assimilated and analyzed within a single agency. This information is provided to licensing board members and law enforcement personnel to give them a comprehensive view of the nature, magnitude, and sources of the prescription drug abuse problem in a state.

The success of the Wisconsin program caught the attention of the American Medical Association, which, as a result of a 1981 House of Delegates resolution, had established a steering committee to study the problem of prescription drug abuse on the national level.

"When I read about the AMA forming this steering committee, I called for more information," says Michael Bateson, Associate Director of the Ohio State Medical Association's Department of State Legislation. "It seemed like a good idea for Ohio since Wisconsin's efforts have not only been extremely successful but cost effective as well. One agency would do the work of five or six." Bateson not only received more information on the committee but an invitation to join it as well. That's when he found out that the committee was planning to establish pilot programs in other states to test the PADS model. Although Ohio was not originally included on that list, Bateson brought the idea back to Ohio with him. Gradually, he began to test the waters to see how the PADS model might best be incorporated here. "Ohio physicians have recently made great strides in recognizing that a prescription drug abuse problem does exist in the state. Resolutions adopted by the OSMA's 1983 House of Delegates demonstrate

this recognition," Bateson says.

Once it was recognized that the abuse of prescription drugs results in more injuries and deaths to Americans than all illegal drugs combined, federal and state agencies began allocating more resources to the solution of this problem.

Bateson says, "Experience nationally has shown that 80% to 90% of diversion occurs at the practitioner and pharmacy level. It is important to recognize however that only a very small percentage of practitioners are involved in the conscious diversion of drugs for profit. What we hope to accomplish first and foremost is to identify those physicians and get them off the street. Then those physicians who might be contributing to the problem either as a result of poor prescribing habits or possible addiction, we want to educate or treat so they can once again practice good medicine. The solution requires a three-pronged approach and by that I mean education (physicians as well as the public), law enforcement, and rehabilitation." The OSMA has long recognized its responsibility in helping the impaired physician, but it is becoming increasingly active in other things that might bring about a reduction of the prescription drug abuse problem. For example, the OSMA strongly supported the move to strengthen the powers of the Medical Board, particularly with regard to the Board's ability to discipline physicians abusing their prescriptive privileges. It also supported legislation to ban look-alike drugs. The *OSMA Journal* has also devoted issues to the subject of prescription drugs in an effort to raise physicians' awareness of the problem and the importance of proper prescribing habits.

Now the OSMA is trying to work with other state agencies in order to develop a coordinated approach to the problem. **OSMA**

Karen S. Edwards



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An added complication... in the treatment of bacterial bronchitis*

Increasing incidence
of ampicillin resistance in
Haemophilus influenzae

Ampicillin Resistant
Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary Consult the package literature for prescribing information

Indications and Usage: Cefclor® (cefadroxil, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (Diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindications: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics including macrolides, semisynthetic penicillins, and cephalosporins. Therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cefclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when anti-tubulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly). Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cefclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.15 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefadroxil

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Cefclor® (cefadroxil, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cefclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hyper-sensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia, and, frequently, fever) have been reported. These reactions are apparently due to hyper-sensitivity and have usually occurred during or following a second course of therapy with Cefclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported; half of which have occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

300035

Guidelines for Proper Prescribing

By Frank Wickham

CONTROLLED SUBSTANCES

Products which contain drugs that have a potential for abuse and whose abuse may lead to physical or psychological dependence are legally classified by both federal and state laws as controlled substances. As the name implies, these products are subjected to additional legal controls regarding their manufacture, distribution, and possession because of their potential for harm if misused.

There are five different schedules into which drugs are placed based upon their potential for abuse and ability to cause physical or psychological dependence when abused. The degree of controls are directly related to the drug's potential for abuse and, consequently, vary with each schedule. The controls extend throughout the whole chain of drug distribution — from the manufacturer to the patient. The controls include registration, manufacturing quotas, record-keeping, security, and requirements regarding the prescribing and dispensing of controlled substances.

Schedule I

Drugs included in this schedule *do not* have a currently accepted medical use, have a high potential for abuse, and are subjected to the most stringent controls. Examples of drugs included in this schedule are heroin, etorphine hydrochloride, and lysergic acid diethylamide (LSD).

In order to conduct research or instructional activities with these drugs, a separate license must be obtained from the federal Drug Enforcement Administration (DEA). These drugs are not available from most commercial sources, require

special security measures for storage, and must be accounted for in detail.

Schedules II through V

Schedules II through V include drugs having a currently accepted medical use. The Schedule II drugs have the greatest potential for abuse, while Schedule V drugs have the lowest potential.

All prescriptions issued for Schedule II through V controlled substances must:

1. be issued for a legitimate medical purpose by a physician acting in the usual course of his/her professional practice. A physician *may not* issue a prescription in order to obtain controlled substances for use in the office. The federal laws and regulations also prohibit the issuing of prescriptions for the purpose of detoxifying or maintaining a narcotic addict.
2. be dated and manually signed by the physician on the day it is issued, in the same manner as he/she would sign a check or legal document, unless it is for a Schedule III through V controlled substance and has been issued orally.
3. bear the full name and address of the patient.
4. have the name of the physician stamped, typed, or hand-printed on it.
5. bear the DEA registration number of the physician. Pharmacists may legally dispense controlled substances only upon receipt of a written or oral prescription issued by a physician licensed to prescribe controlled substances by the DEA. The DEA registration number appearing on a written prescription,

or provided to the pharmacist by a physician issuing an oral prescription, indicates that the prescriber is licensed to prescribe controlled substances. The pharmacist may then verify whether the registration number is legitimate by using a mathematical formula and calling the regional DEA office. Consequently, it is recommended that the DEA registration number not be pre-printed on the prescription blank, since it is used in determining whether or not the prescription is valid and has not been forged. Printing the registration number on the blank makes a legitimate registration number readily available, and it may be used by persons who forge prescriptions to obtain drugs for illegal use and sale.

Schedule II

A written prescription must be issued by a physician if he/she wishes the patient to obtain a Schedule II controlled substance. Examples of drug products included in Schedule II are morphine, hydromorphone (Dilaudid®), oxycodone (Percodan®), phenmetrazine (Preludin®), secobarbital (Seconal®), and methaqualone (Quaalude®).

Prescriptions for Schedule II controlled substances may not be refilled, and a new written prescription must be issued by the physician in order for the patient to obtain additional quantities of Schedule II drugs.

The only time that a written prescription is not required is in an emergency situation, as defined by the Secretary of the United States Department of Health and Human

Services. A physician may verbally authorize a pharmacist to dispense Schedule II controlled substances to a patient in these situations where he/she has determined that:

1. **immediate administration of the controlled substance is necessary for the proper treatment of the patient;**
2. **there is no appropriate alternative treatment, including administration of a drug which is not a Schedule II controlled substance; and,**
3. **it is not reasonably possible for the physician to provide a written prescription to the pharmacist before the drug is dispensed to the patient.**

The oral authorization to dispense Schedule II controlled substances in an emergency situation is legal only if:

1. **the quantity prescribed and dispensed is limited to the amount which is necessary to treat the patient during the emergency period; and**
2. **the pharmacist is provided a written prescription by the physician within 72 hours following receipt of the emergency oral prescription. The written prescription is required to have written on its face, "Authorization for Emergency Dispensing," and the date of the oral order, as well as all the information required for all controlled substance prescriptions listed previously. Pharmacists who do not receive the written prescription within the 72-hour time period are required to notify the nearest office of the DEA.**

Schedules III and IV

Schedule III and IV controlled substances may be prescribed orally by a physician. Some examples of drugs included in Schedule III are benzphetamine (Didrex®), phendimetrazine (Ionamin®), glutethimide (Doriden®), and Empirin® No. 1 through No. 4. Products such as chloral hydrate (Noctec®), chlorthalidopoxide (Librium®), oxazepam (Serax®), and pentazocine (Talwin®) are Schedule IV controlled substances.

Five refills may be authorized when issuing a prescription for a Schedule

III or IV drug product. These refills can only be obtained within six months from the date that a prescription for a Schedule III or IV drug is issued. A new prescription must be issued, however, if additional quantities of Schedule III and IV drugs are needed beyond six months, or five refills, whichever occurs first.

Schedule V

Schedule V controlled substances include both prescription drug products and over-the-counter drug products. An example of a Schedule V product which may be obtained only by prescription is Phenergan VC® Expectorant with Codeine. Some Schedule V drug products which may be purchased without a prescription from a pharmacy include Lomotil®, Robitussin AC®, and Phenergan® with Codeine.

Prescriptions for Schedule V controlled substances may be authorized for refill for no longer than one year from the date that the prescription was issued.

DEA Registration

Another of the controls provided by the federal Controlled Substance Act is the registration of persons who are involved in the distribution of controlled substances. Included in the requirements for registration are physicians who prescribe and administer or dispense controlled substances. If a physician has more than one office, each office where controlled substances are stored for the purpose of administration or dispensing to patients must be registered with the federal DEA.

Records

Physicians who are registered with the DEA to store controlled substances for the purpose of *administration* or *dispensing* at a specific office are required to keep records consisting of:

1. **the third copy of official order forms which were used to purchase Schedule II controlled substances, and have been completed by the physician with the number of packages received and the date they were received;**
2. **invoices of all Schedule III through**

V controlled substances purchased by the physician;

3. **non-narcotic controlled substances administered to patients;**
4. **narcotic controlled substances dispensed to patients;**
5. **non-narcotic controlled substances dispensed to patients if the patient is charged for such controlled substances; and,**
6. **a biennial inventory of all controlled substances stored at the registered location. An inventory of all controlled substances on hand must be taken every two years following the date that the initial inventory was made when the office was opened. An exact count and measure must be made of all Schedule II controlled substances and Schedule III, IV, or V controlled substances in packages containing 1,000 or more tablets or capsules. An estimated count may be made of packages which originally contained less than 1,000 tablets or capsules of Schedule III, IV, or V controlled substances.**

All controlled substance records must be readily retrievable and maintained at the registered location for inspection and copying by federal, state, and local drug law enforcement authorities for a period of two years.

Dispensing of Controlled Substances — Labeling

Physicians who dispense controlled substances to their patients in the course of their professional practice are required by state law to affix a label to the container bearing:

1. **the physician's name and address;**
2. **the name of the patient;**
3. **directions for use of the controlled substance;**
4. **the date the controlled substance was dispensed; and,**
5. **the following warning: "Caution: Federal Law Prohibits The Transfer Of This Drug To Any Person Other Than The Patient For Whom It Is Prescribed."**

Patients may not legally possess controlled substances unless they are in the original container in which they were dispensed and it is illegal for any person to alter, deface, or remove the

affixed label as long as any of the original contents remain in the container.

Required Reports

Any loss or theft of controlled substances is to be reported, in writing, to the State Board of Pharmacy and the federal DEA, when discovered. Forms will be forwarded from the State Board of Pharmacy office when notification is received.

Any loss or theft of prescription blanks and official written order forms also is required to be reported to the State Board of Pharmacy when

discovered. No official form is necessary and the report may be made by telephone.

Disposal of Controlled Substances

Physicians who have controlled substances that they no longer wish to carry in their inventory should contact the State Board of Pharmacy or the district office of the federal DEA, and request authority and instructions to dispose of the drugs. The request must include the physician's name and the address of the site where the drugs are stored, and the name and quantity of each controlled substance to be destroyed. **OSMA**

For further information on this subject, contact:

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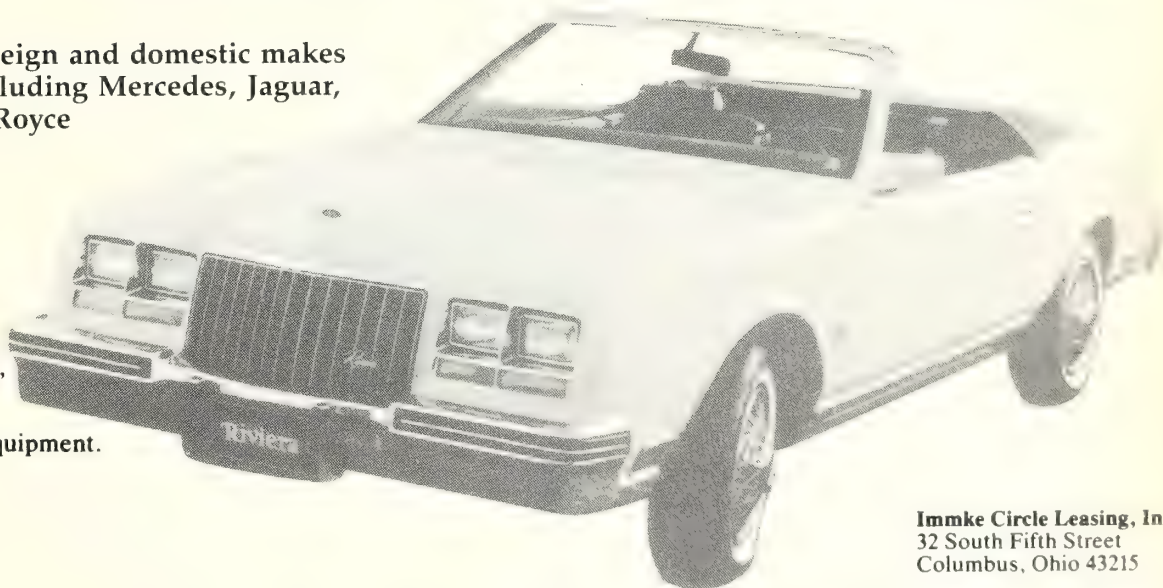
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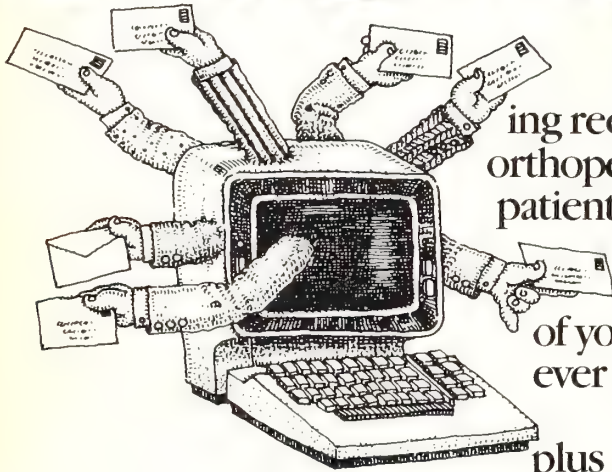
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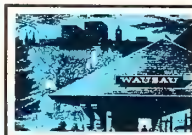
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Epilogue

By Charles N. Hoyt, M.D.

"Those who . . . survive their illness or overcome their handicap and take their places back in the world have a depth of spirit you and I can hardly measure." — Dr. Howard Rusk

Perry Ayres, M.D., left us with an image to be envied and a legacy to be desired. In a few short years he accepted and met the challenge posed by the alcohol and/or drug dependent individual, in particular, the impaired physician. The result has been OSMA's Physicians' Effectiveness Program* and an impressive number of grateful, recovering patients. Borrowing loosely from a passage in "The Merchant of Venice," Perry's good deeds shone in a naughty world.

This special article was to have been written by Dr. Ayres and might well have included comments on the "sick" doctor and OSMA's approach to his problem. It most certainly would have contained one or more of Perry's acronyms, the inventing of which was one of his literary pastimes.

In order to do justice to the task at hand, in his honor and memory, it is only fitting that quotations picked from Dr. Ayres' numerous articles on the alcohol and drug dependent doctor be used here.

Dr. Ayres defined the impaired physician in two short paragraphs:

"Organized medicine acknowledges a distinction between the 'bad doctor' and the 'sick doctor,' the latter being identified as an impaired physician. He is a physician affected by psychiatric disorder, alcoholism or drug dependency. He is an impaired physician because he is an impaired person.

"The impaired physician generally has a premorbid history of integrity, dedication, and professional competence. Most often he is an emotionally isolated "workaholic" whose coping skills have atrophied

Another shocking estimate finds 600 physicians lost each year to alcoholism and drug dependence. The accuracy of this statement is unimportant; the critical issue is: What's being done about it?

and whose identity as a person is lost behind the shield of physicianhood. Impaired self-perception is his hallmark."

Dr. Ayres continued on the subject of impairment in "The Physician Alcoholic — A R C H** to Recovery":

"Performance of a physician can be impaired by many things — by

senility, by ineptitude, by incompetence, by dishonesty. But those accessible to treatment are psychiatric disorders, drug addiction, and alcoholism. It is the latter two that are mentioned most often, and it is the alcoholic physician who is most readily identified."

Drug addiction as an occupational hazard among physicians has long been recognized. But when pejoratives such as "disgrace" and "stigma" are replaced by the more accurate term "illness," the extent of the problem surfaces. Drug dependence in doctors often is said to be between 10 and 30 times that of the general population. Although there are undoubtedly predisposing physical and psychological factors, the high rate of addiction in physicians appears to be

* Dr. Ayres was the Chairman of the Physicians' Effectiveness Program of the Ohio State Medical Association from 1977 until his death on May 28, 1983. This program has functioned successfully and its scope, mechanisms and intent are discussed in several articles in the November 1977 issue of the *Ohio State Medical Journal*. There also is available upon request from Mr. Robert Clinger a packet of information about the PEP and other states' approaches to the impaired physician.

** A R C H for Acceptance, Recognition, Confrontation and Hope; this paper appeared in the November 1977 issue of the *Ohio State Medical Journal*.

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related to easy accessibility to controlled substances and a **marked** tendency toward treating self.

Another shocking estimate finds 600 physicians lost each year to alcoholism and drug dependence. The accuracy of this statement is unimportant; the critical issue is: What's being done about it?

In a series of articles appearing three years ago in *The Bulletin* (publication of the Academy of Medicine of Columbus and Franklin County) entitled "Do You Know a Sick Doctor?", Dr. Ayres wrote:

"It has only been a few years since organized medicine acknowledged a distinction between "sick" and "bad" doctors and became aware of the reality that many of those impaired by psychiatric illnesses, alcoholism, and other drug abuse can be identified, effectively treated, and returned to professional activity. Physicians of most of the 50 states have begun or are planning programs for this purpose.

"These are programs of identification and intervention by concerned colleagues, who lead the sick physician to treatment and give him a chance for recovery. They are designed to provide help rather than punishment, and they employ persuasion before coercion. However, many of the programs recognize the moral and legal obligation to inform state licensing boards of the impairment if a sick colleague fails to comply."

In discussing treatment of the sick doctor, Dr. Ayres elaborated:

"Management of the impaired physician involves four roles. These must be sharply delineated and the delineation must be clearly understood and respected by each participant, so I have employed the acronym PACT for Patient, Authority, Colleague, and Therapist.

"*Patient*: It is an aphorism that most physicians adapt to the role of patient with utmost difficulty. This is especially true of the physician impaired by psychiatric illness or substance abuse. By the time they reach treatment, they already have tried more than once to usurp the other roles. They have lectured to

themselves as authorities, they have pitied themselves as they believe only a sympathetic colleague could or should, and they have tried to treat themselves. Now, they must be induced to accept the patient role. To the extent they are able to do so, they have a chance for recovery.

"*Authority*: This may be the courts, licensing boards, hospital administration, partners, or others — any person or body having the power to affect their lives in a major way, especially their professional lives. Such authorities may be helpful in motivating the sick doctor to accept and complete treatment, and they often must be dealt with in the process of reentry into professional activity.

"*Colleague*: From first to last, the concerned colleague must be firm, but must convey to the physician-patient an attitude of hope and empathy. It is for this reason that physicians who have experienced similar impairment are especially effective in the intervention process. . . .

Physicians must realize that the greatest kindness they can offer their sick friend is to insist firmly that he/she seek help from a skilled and otherwise disinterested therapist . . .

"*Therapist*: If he is able to reach out for help, the sick doctor is prone to consult the wrong person for the wrong reason. Most often this is a physician friend who is ill-prepared to treat him and who he manipulates disastrously. Physicians consulted in this manner must avoid such a trap. They must realize that the greatest kindness they can offer their sick

friend is to insist firmly that he seek help from a skilled and otherwise disinterested therapist. . . ."

Dr. Ayres had much compassion for his suffering colleagues. He was as concerned about the education of young doctors in the subspecialty of alcohol/drug dependence as he was the appropriate treatment of the problem. His concluding remarks in his article "Do You Know a Sick Doctor?" stated:

"PREVENTION: A CAVEAT AND A BENEDICTION — It is important that we alert our colleagues, especially those just entering our profession, to their personal risk.

"In 1978, 40 years after I entered medical school, I was privileged to address the incoming class at the Ohio State University College of Medicine on the subject of substance abuse.

Following are the caveat and benediction with which I concluded that talk:

"You are at risk because of the kinds of people you are, because of the kind of profession you are entering, and because of the kinds of people we, your teachers and colleagues, are.

"From 40 years away, I offer you this benediction:

- Remember, you were a person before you were a doctor;
- Recognize your own needs and attend to them;
- Pace yourself;
- Temper your dedication;
- Keep balance in your life;
- Learn to play — to give to yourself in healthy ways;
- Give to one another and learn to receive;
- Reach out, and encourage others to do so;
- Be alert to problems among your peers in this brotherhood of medicine;
- Be prepared to help each other; and
- **BE YOUR BROTHER'S KEEPER.**

OSMA

Charles N. Hoyt, M.D., Columbus, is a member of OSMA's Impaired Professionals Committee. He is retired from his practice in internal medicine and the treatment of alcoholism, and he resides in Galena, Ohio.

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Understanding DRG's, Part I

By Rebecca J. Doll

"A sound market needs sound antitrust oversight. That includes medicine. The only agency that has sufficient insulation from political pressure is the Federal Trade Commission (FTC). You (medicine) need it! But you're fighting the wrong battle. Medicare is flirting with public utility reimbursement. Is medicine over at the Medicare debate? No . . . you can't find a lobbyist. They're all over at the FTC. You're in the wrong battle and you're going to lose the war."

— Walter McClure, Ph.D.,
President, Center for Policy Studies,
speaking at the OSMA Leadership
Conference, November, 1982.

On March 24, 1983, less than four months after Dr. McClure made his prophetic statement, Congress signed into law the Social Security Amendments of 1983. Tacked onto the amendments was a proposal aimed at overhauling the Medicare reimbursement system for hospitals. Hailed as the most widesweeping change in the 17-year history of the program, the proposal breezed through Congress after it was proposed by the Reagan Administration.

The goal of the new system is to cut Medicare costs — which some analysts claim will double to \$110 billion by 1987 if there are no changes in current trends — before they are incurred, via a method known as prospective payment. Under the prospective payment plan, hospitals would be paid on the basis of prospectively determined rates for each of 467 categories of illness known as diagnosis-related groups, or DRGs.

The idea, says Dr. McClure, is to pay hospitals based on a cost per discharge or admission, adjusted for case severity, rather than on cost per day, which "encourages overutilization." He adds that since

Like it or not, the DRG payment system is now the law of the land and physicians, not surprisingly, are next in line.

the hospital will know in advance what it will be paid for various procedures, it forces the hospital to be more cost efficient.

"Presumably, the hospital which can produce the admission for less than

the predetermined amount, is going to make it. Those which can't, won't," McClure says.

The plan will take effect on October 1, 1983, at the beginning of the hospitals' fiscal year. To ease the pain for hospitals, the plan is scheduled to be phased in over a three-year period. Different national rates will be set for urban and rural hospitals with rates varying in each of nine geographic regions.

At the beginning of this fiscal year, 75% of a hospital's Medicare payment will be based on the hospital's own costs and 25% on DRGs. In the second year, payments will be half and half. The third year, 75% of the payments will be DRG-based and in 1987, the DRG plan will be fully operational. Exempted from the plan are psychiatric and rehabilitation hospitals, hospitals whose inpatients are primarily under 18 years of age

continued on next page

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☐ Afternoon Session - 12:30 p.m. - 4:30 p.m.

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and hospitals whose average length of stay is over 25 days.

Although the legislation allows for continued reimbursement of capital expenditures on a "reasonable cost" basis until 1986, it instructs the Department of Health and Human Services (HHS) to conduct a review of methods for including capital expenses in the prospective payment system.

Another modification of the DRG reimbursement scheme is the requirement that each hospital contract with a Professional Review Organization (PRO). The PRO will be responsible for reviewing the validity of diagnostic information provided by the hospitals for the purposes of payment, the completeness and adequacy of care, the appropriateness of admissions and the appropriateness of care provided outlier cases (i.e., cases where the length of stay exceeds, by some significant amount, the average length of stay for cases within the same DRG).

At the time of this writing, rules under which the PROs will operate had not been promulgated. A May 1983 OSMA House of Delegates directive requires the OSMA Council to review the rules when they are issued to determine the feasibility of the OSMA serving as the PRO in Ohio.

Supporters of DRG including the Federation of American Hospitals, which represents about 1,000 investor-owned institutions, and the 6,300-member American Hospital Association, representing voluntary, not-for-profit hospitals, say the new payment system is necessary and much needed.

Leading the opposition was the health insurance industry which feared that hospitals would shift costs to their non-Medicare patients and their private insurance companies in order to make up for any losses incurred under DRG.

Also registering its opposition were the American Medical Association, the American Nurses Association and the National Council of Senior Citizens. Citing accessibility and quality problems, the AMA Council on Medical Services issued a report to the AMA House of Delegates at its July interim meeting warning that "the

application of these untested financing mechanisms to virtually all Medicare hospitalizations is fraught with potential dangers to the quality and accessibility of care for all patients."

The Council cited four major areas of concern:

- Whether DRGs have demonstrated their effectiveness as a methodology for hospital payment, much less payment for physicians' services.

- How a DRG-based payment system will affect the delivery of care, particularly its impact on quality and accessibility of care.

- Whether the new program will shift costs of the Medicare program to the private sector.

- Whether the initial and ongoing administration costs incurred by all hospitals in using DRGs will be

Like it or not, the DRG payment system is now the law of the land and physicians, not surprisingly, are next in line. Congress left the door open to physician involvement by including a clause in the Medicare legislation which requires the secretary of HHS to report in 1985 on the advisability and feasibility of extending DRG payments to Medicare charges incurred by physicians for services rendered in a hospital. Robert Fetter, the Yale University professor who designed DRGs, says there already is enough information to set up physician DRGs for surgical procedures and that DRG payment rates for long-term and ambulatory care are in the final stages of preparation.

Supporters of DRG, including the Federation of American Hospitals, which represents about 1,000 investor-owned institutions, say the new payment system is necessary and much needed.

greater than the cost savings anticipated, since only 25% of the average hospital caseload is Medicare beneficiaries.

Although the phase-in nature of the program may prevent immediate fiscal problems for hospitals, the Council warned that "hospital management will almost assuredly be seeking now to reduce length of stay and use of ancillary services to conform to anticipated DRG payment rates."

Other analysts agree and predict that the most friction probably will occur over average length of stay of patients. Hospitals, tied to a set payment rate, will put pressure on physicians to cut down on the average length of stay, a move which many physicians view as interference with a strictly medical decision.

However, Ohio Hospital Association President Don Newkirk predicts cooperation between the hospital administration and physicians. "There is no way, in my estimation, that a hospital can operate under this new system without a very, very good working relationship with the medical staff."

How the new system ultimately will affect hospitals, physicians and patient care remains to be seen. What is clear, however, is that Congress, under pressure to produce a cost efficient, affordable system of health care for the single fastest growing segment of the population — the elderly, intends to see to it that the DRG system gets a fair shot at resolving the problem, with or without medicine's support.

OSMA

Next Month: What Ohio's hospitals are doing to prepare for the coming of DRGs.

Rebecca J. Doll is an Associate Executive Director of the Ohio State Medical Association, and Director of its Department of Communications.

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5. Detailed disclosure of claims data	YES	_____
6. Contractual profit sharing agreement	YES	_____
7. Physician consent for settlement of claim prior to judgement	YES	_____
8. Legal defense services provided only by specialists in defendant medical professional liability insurance suits	YES	_____
9. No pre-paid legal expense	YES	_____
10. Refusal to pay nuisance claims	YES	_____
11. Premiums to surplus ratio of less than 2-1	YES	_____
12. "Clean" opinion from auditors	YES	_____
13. Steady growth in surplus, claims reserves, and operating profits	YES	_____
14. Physician decisions on claims and underwriting matters	YES	_____
15. Official endorsement by the OSMA	YES	_____

When you're asked to compare the price of your medical professional liability insurance coverage, we suggest that you also compare quality. When your claim arises, now or several years in the future, the quality of your coverage, claims services, and the company standing behind you is what really matters.



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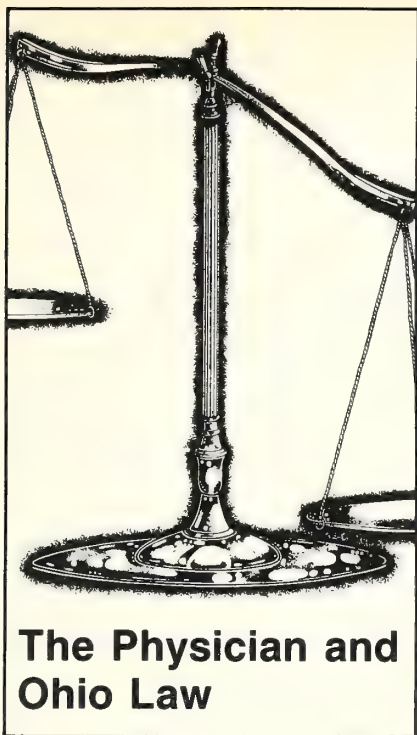
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"The Physician and Ohio Law" is being introduced as a column in the Journal in response to the growing number of legal questions which are addressed to OSMA from the county societies and OSMA members. The column will focus on legal issues — such as developing medical-legal areas and Ohio Supreme Court decisions — and on regulatory matters which affect physicians (for example, State Medical Board actions and Department of Health activities). Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

The Discovery Rule

By D. Brent Mulgrew, J.D., and Catherine C. Costello, J.D.,

Oliver v. Kaiser Community Health Foundation (Ohio Supreme Court, June 8, 1983).

Summary of the court's decision: "Under Ohio Revised Code 2305.11 (A) i.e., Ohio's medical malpractice statute of limitations), a cause of action for medical malpractice accrues and the statute of limitations commences to run when the patient discovers, or in the exercise of reasonable care and diligence should have discovered, the resulting injury."

The *Oliver* case is a lawsuit brought by a woman against the pathologist and hospital involved in her surgery in 1975. The woman had been operated

on by a pathologist after the initial diagnosis in 1975.

Ohio's malpractice statute of limitations reads as follows:

"An action for . . . malpractice against a physician, podiatrist, or a hospital . . . shall be brought within one year after the cause thereof accrued . . ." ORC 2305.11 (A)

Prior to 1975, the one-year limitation had been interpreted in Ohio to mean one year from the time the alleged malpractice occurred or, at the latest, one year from the termination of the physician-patient relationship. This is the so-called "termination rule." Exceptions existed

Under the discovery rule, there is no definite period of time from the alleged malpractice within which a patient has to file a malpractice suit. Rather, the point in time when the patient discovers, or with reasonable care and diligence should have discovered, the results of the alleged malpractice, is the time when the statute of limitations begins to run. This means that a physician may be liable to a patient indefinitely.

on for the excision of a lymph node from the right axilla. The pathologist who examined the tissue specimen reported it was nonmalignant. Four years later, the woman was diagnosed as a carcinoma and died within six months.

The lawsuit was filed in 1979 four years after the original surgery. The woman had had no further physician-patient relationship with the

pathologist after the initial diagnosis in the case of minor children and in the case of a foreign body left in the patient after surgery.

In 1975, in response to the medical malpractice crisis, the Legislature significantly amended the Ohio statute of limitations by adding the following language in Section 2305.11:

"(B) In no event shall any medical claim against a physician,

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podiatrist, or a hospital be brought more than four years after the act or omission constituting the alleged malpractice occurred . . ."

This language was in addition to the one year statute of limitations which continued to exist for most malpractice cases. The Legislature intended the section (B) amendment to act as an absolute cap in *all* medical malpractice actions except for cases involving minors under the age of ten. Children under ten had until their fourteenth birthday to bring a lawsuit.

On June 8, 1983, when the *Oliver* opinion was released, the court established the "discovery rule" as the means of calculating the beginning of the application of the statute of limitations.

Under the discovery rule, there is no definite period of time from the alleged malpractice within which a patient has to file a malpractice suit. Rather, the point in time when the patient discovers, or with reasonable care and diligence should have discovered, the results of the alleged malpractice, is the time when the statute of limitations begins to run. The patient then has a year from the point of discovery to file a lawsuit. This means that a physician may be liable to a patient indefinitely.

In the *Oliver* opinion, the court never cites the language in Section 2305.11 (B) relating to the four year limit on malpractice actions, nor attempts to explain how the four year bar works in reference to the discovery rule. Justice Holmes in the sole dissent strongly criticized the majority opinion for refusing to address the relationship between the new discovery rule and the statutory language limiting malpractice actions to four years from the date of the alleged malpractice. He accused the majority of overriding the clear intent of the Ohio Legislature and establishing public policy which is contrary to that expressed in the statute.

The full impact of this decision is not really known. If in fact the four-year limit on malpractice actions has been discarded in favor of an open-ended discovery rule, the effect could be enormous. Record retention policies which have been developed in light of

Ohio's statute of limitations now will have to be reformulated. The potential for open-ended liability may also be reflected in increasing premium rates for malpractice insurance. However, a review of the facts **may** permit the continued application of the four-year limitation on medical claims. A more detailed analysis of this issue is underway and more information will be presented later.

Until there is some clarification of the *Oliver* opinion, Ohio physicians are left with numerous unanswered questions as to their potential liability to medical malpractice allegations more than one year after cessation of the physician-patient relationship.

D. Brent Mulgrew, J.D., and Catherine Costello, J.D. are in OSMA's Department of Legal Affairs and serve as OSMA's Staff Counsel.

Positions on Medical Board filled by Celeste

Two positions on the Ohio State Medical Board have been filled by Governor Celeste. **Leonard L. Lovshin, M.D.**, of Aurora, has been reappointed for a five-year term. Dr. Lovshin is currently serving as the Board's Vice-President.

John E. Rauch, D.O., of Logan, has been appointed to a five-year term, replacing **Evelyn L. Cover, D.O.**, whose term expired April 25, 1983. Dr. Cover served as the Medical Board's President for a number of years.

Both appointments are subject to approval by the Ohio Senate. **OSMA**



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CLINICAL NOTES

Edited by Karen S. Edwards

Effects of a Seat Belt Law on Child Restraint Use

In August, 1976, Quebec enacted legislation requiring the use of seat belts by all front seat passengers weighing more than 23 kg. A series of observations, extending throughout six years, were performed to assess its impact on children. Prelaw rates showed 6.4% restraint use for children aged 0 to 11 years and 14.7% for drivers. In the year after legislation, rates for both drivers and children more than doubled and had increased to 55.5% and 24.5% respectively, in 1981. The child's age and parent's use of a seat belt were important factors associated with restraint use among children.

Further study results show that, of all children, those younger than 1 year of age most often are restrained. In the last three years of observations, it has been noted that children older than 5 years of age have started to show restraint rates, comparable with those of drivers. However, a large majority of children older than 1 year of age still travel without protection.

Nevertheless, results seem to suggest that the law is of indirect benefit to children, by inspiring parents to provide their child with the same protection being demanded of themselves.

*American Journal of Diseases
of Children*

Volume 137, Number 6, June, 1983

pgs. 582-585

Heavy Use of Antacid Tablets

Proprietary antacids represent a multimillion dollar business in this country. Marketing surveys have shown that approximately one-half of all American adults have used antacids. Twenty-seven percent of adults take two or more doses per month. Seventy-five percent of total antacid consumption is by heavy users, defined as more than six doses per week. The authors investigated why apparently healthy people are heavy antacid users. Thirty-seven heavy users were evaluated. The median duration of antacid use was 20 years, and most took antacids two to six times per day, concentrated through the work week. The primary diagnosis was reflux esophagitis in 31, peptic ulcer disease in one, and nonulcer dyspepsia in five. Ninety-five percent had symptoms consistent with reflux esophagitis. Thirty-three completed a one-month double-blind, randomized cross-over trial of antacid tablets versus placebo. Twenty-nine correctly identified the antacid product. Twenty-three subjects underwent Bernstein tests and endoscopy; 21 had positive Bernstein tests, 13 had definite esophagitis as determined endoscopically. The authors conclude: 1) heavy proprietary antacid tablet use in the adult male is not an expression of functional disease but is due to reflux esophagitis; 2) tablet use can be effective symptomatic treatment; and 3) history is an adequate evaluation for most heavy antacid tablet users.

*The American Journal of
Gastroenterology*

Volume 78, Number 5, May, 1983

pgs. 257-260

Pediatrics and the Psychiatric Referral

There are five basic questions that the pediatrician should consider if he suspects a child with an apparent

psychosomatic complaint may require a psychiatric referral.

The first question to consider is whether to conduct an evaluation of the child's health on an outpatient or inpatient basis. Unless the family is highly resistant to treatment, the child is excessively incapacitated or the family has a history of "doctor shopping," an outpatient evaluation is recommended.

The second question the pediatrician must ask is whether to manage the case or make a psychiatric referral. The pediatrician's time, interest, and expertise will influence this decision, as will the complexity of the problems, the family's response, and the degree of rapport felt toward child and family.

A third point to consider is whether to personally conduct a conference with the family or to hold the conference jointly with a psychiatrist. Joint conferences are most useful when a pediatrician's recommendations for referral go unheeded, and can be invaluable during times of medical/family crisis, when it reinforces both physicians' commitment to help the family regain their equilibrium. When a personal family conference is called for, it is best conducted with the parents alone, first, then with child and parents.

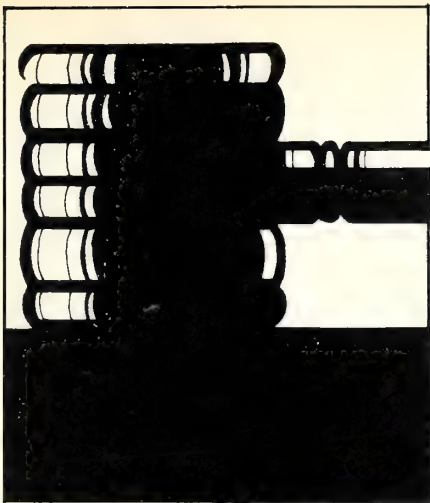
Should the pediatrician offer a direct or indirect explanation of the symptom? The pediatrician must individualize his approach with the family, based on their needs at the time of contact. By observing the family's reaction to his approach, he can guide his subsequent comments to the family.

The final question is, again, one of approach. Should the pediatrician refer the patient for a time-limited psychiatric evaluation, or for a more open-ended psychiatric treatment? As the authors suggest, a family may more readily agree to four evaluation sessions than to an initial proposal of ongoing treatment. Each case would, of course, have to be decided individually.

Clinical Pediatrics

Volume 22, No. 3, March, 1983

pgs. 167-172



council proceedings

May 13, 1983

A regular meeting of the Council of the Ohio State Medical Association was held Friday, May 13, 1983, at the Hyatt Regency Hotel, Columbus.

Those present were: S. Baird Pfahl, Jr., M.D., Sandusky; Stewart B. Dunsker, M.D., Cincinnati; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abramowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Delta; Edward G. Kilroy, M.D., Cleveland; J. James Anderson, M.D., Youngstown; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; Oscar W. Clarke, M.D., Gallipolis; Mrs. Rose Vesper, President, OSMA Auxiliary, New Richmond; and James E. Pohlman, Esq., OSMA Legal Counsel, Columbus.

Those present from OSMA Staff were: Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; D. Brent Mulgrew, Esq.; Robert D. Clinger; Katherine E. Wisse; Robert E. Holcomb; Gail E. Dodson; Eric Burkland; William E. Fry; Carol W. Mullinax; Michael L. Bateson; Catherine M. Costello, Esq.; Louis N. Saslaw; Aristotle Hutras; Carol M. Maddy; and Rebecca J. Doll.

The meeting was called to order by President-Elect S. Baird Pfahl, Jr., M.D., in the absence of President C. Douglass Ford, M.D.

The Council voted to endorse the following candidates for the opening on the Ohio State Medical Board: Max D. Graves, M.D., Springfield; John P. Kempf, M.D., Toledo; Deirdre M. O'Connor, M.D., Toledo; and Sidney Peerless, M.D., Cincinnati.

The Council reviewed the pending resolutions of the House of Delegates and individual Councilors expressed interest in providing information on specific resolutions when they are discussed by the resolutions committees.

The Council indicated its desire that Resolutions No. 14-83 and No. 15-83 be brought up at the second session of the House of Delegates.

Auditing & Appropriations Committee

Dr. Payne presented the minutes of the May 12, 1983, meeting of the Committee on Auditing and Appropriations.

The Council **approved** the Committee's recommendations in the following matters:

1. Establishment of a budget for the Ohio Medical Education and Research Foundation, covering projected 1983 and 1984 operating costs.
2. Payment of funds for the 1982 Auxiliary Matching Fund Program and extension of program into 1983.
3. Deferment of the OSMA Leadership Conference in 1983. A committee was suggested for study of future leadership programs.
4. Nonextension of the lease on 622 South High Street and acceptance of bids for razing the building on the property.
5. Purchase of word processing printers and terminals at a cost of \$8,000.

The minutes as a whole were **approved**.

State Legislation

Mr. Burkland presented information on current legislation. The issues were discussed and the Council provided direction to the staff as indicated.

HB 358 — Institutional Employment of Physician's Assistants:
REAFFIRMED OPPOSITION.

HB 289 — Electrolysis — to move the licensing from the Medical Board to the Cosmetology Board and to

lower education requirements:

VOTED OPPOSITION.

SB 204 — Nurse Midwifery Hospital Co-Admitting Privileges and Direct Reimbursement: **VOTED OPPOSITION.**

SB 160 — Local Public Hearings Prior to Certificate of Need: **VOTED THAT FUNDS BE APPROPRIATED TO PROVIDE FOR LOCAL HEARINGS.**

SB 187 — Use of Pharmaceutical Agents by Optometrists:
CONTINUE OPPOSITION.

Specialty Society Representation

After meeting the membership requirements specified in the OSMA Bylaws, the following specialty societies were approved for representation in the House of Delegates for the 1983 Annual Meeting: Ohio Society on Anesthesiology; OSMA Section on Dermatology; Ohio Academy of Family Physicians; Ohio State Neurosurgical Society; Ohio Ophthalmological Society; Ohio Orthopaedic Society; Ohio Society of Otolaryngology; Ohio Society of Pathologists; Ohio Chapter, American Academy of Pediatrics; Ohio Society of Physical Medicine and Rehabilitation; Ohio Chapter, American College of Physicians and Ohio Society of Internal Medicine; Ohio Psychiatric Association; and Ohio State Radiological Society.

Task Force on Medicaid

Dr. Irons addressed the Council with regard to the work of the Task Force on Medicaid.

Dr. Irons announced that he has been appointed to the Governor's Commission on Ohio Health Care Costs and discussed the first meeting of that Commission with the Governor.

Considerable discussion followed Dr. Irons' report.

It was suggested that the Task Force meet again as soon as possible and that directions be developed for guidance of Dr. Irons in his work with the Commission, and for OSMA leadership in dealing with this and related matters.

Dr. Dunsker Commended

The Council voted to commend Dr. Dunsker for the excellence of his service as Councilor, President-Elect, President and Past President, and to thank him for his conscientious attention to his duties in those positions.

Dr. Pfahl presented a gift to Dr. Dunsker on behalf of the Council.

Dr. Dunsker addressed the Council.

PICO Board

A proposal for PICO Board rotation was presented by Dr. Pfahl who transmitted a message from Dr. Ford.

The Council referred the proposal to the Tenure Committee of PICO and asked that a reply be received for Council's consideration in September.

ATTEST: Hart F. Page, CAE
Executive Director

May 16, 1983

A regular meeting of the Council of the Ohio State Medical Association was held Monday, May 16, 1983, at the Hyatt Regency Hotel, Columbus.

Those present were: S. Baird Pfahl, Jr., M.D., Sandusky; A. Burton Payne, M.D., Ironton; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Delta; J. James Anderson, M.D., Youngstown; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; Thomas P. Price, Jr., M.D., Gallipolis; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; Oscar W. Clarke, M.D., Chairman, AMA Delegation, Gallipolis; W.J. Lewis, M.D., Member, AMA Board of Trustees, Dayton; William Dorner, Jr., M.D., Member, Ohio Delegation to AMA, Akron; John J. Gaughan, M.D., Member, Ohio Delegation to AMA, Elyria; Mrs. Stella Brown, President, OSMa Auxiliary, Dayton; and James E. Pohlman, Esq., OSMa Legal Counsel, Columbus.

Those present from OSMa Staff were: Hart F. Page, CAE; Herbert E.

Gillen; Jerry J. Campbell; Robert D. Clinger; D. Brent Mulgrew, Esq.; Katherine E. Wisse; Gail E. Dodson; Robert E. Holcomb; Rebecca J. Doll; Eric Burkland; Louis N. Saslaw; Catherine M. Costello, Esq.; William E. Fry; and Aristotle Hutras.

Presidential Announcements

Dr. Pfahl called the meeting to order and introduced the new Ninth District Councilor, Thomas P. Price, Jr., M.D., Gallipolis, and Mrs. Stella Brown, new Auxiliary representative to the Council.

Dr. Pfahl thanked Mrs. Dodson for the Annual Meeting arrangements.

Committee Appointments

The President's appointments to OSMa Committees for 1983-1984 were ratified and confirmed by the Council.

Task Force on Health Care

Dr. Irons reported on the May 14, 1983, meeting of the Task Force on Health Care (formerly Task Force on Medicaid).

He announced that Dr. Joseph F. Boyle, Chairman of the AMA Board of Trustees, was a participant in the discussion.

Dr. Irons summarized the progress of the deliberations for the information of the Council.

Hospital Medical Staff Section

Dr. Oscar W. Clarke and Dr. William Dorner, Jr., discussed the development of a Hospital Medical Staff Section.

Resolution on Provider Organizations

The Council approved for submission to the AMA House of Delegates, in response to OSMa House of Delegates Resolution No. 45-83, the following resolution:

WHEREAS, Different preferred provider organizations exist and new PPO structures are developing; therefore be it

RESOLVED, That the American Medical Association develop guidelines to analyze various PPO structures as they affect:

- 1) A patient's freedom of choice of hospital and physician;
- 2) The patient's ability to make decisions involving his health care through economic incentives and disincentives;
- 3) The physician's ability to participate (in the plans); and
- 4) The use of utilization review data to control physician participation.

ATTEST: Hart F. Page, CAE
Executive Director



Thomas Price, Jr., M.D.

New Councilor named to serve Ninth District

THOMAS PRICE, JR., M.D., recently has been named the new Ohio State Medical Association (OSMA) Councilor for the Ninth District. Dr. Price is chairman of the obstetrical/gynecological department at the Holzer Medical Clinic, Gallipolis, Ohio. He is a diplomate of the American Board of Obstetrics and Gynecology.

A 1949 graduate of Northwestern University, Dr. Price took his residency at the University of Cincinnati, before beginning private practice.

Dr. Price is a member of the OSMa and has served as a delegate for twelve years.



CONTINUING EDUCATION PROGRAMS

August

33RD ANNUAL SCIENTIFIC ASSEMBLY: August 12-14; Hyatt Regency Hotel, Columbus; sponsor: Ohio Academy of Family Physicians; 13-1/2 credit hours; no fee; contact: Mrs. Florence I. Landis, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

September

CURRENT ISSUES IN OCCUPATIONAL MEDICINE: September 17; The Resort Inn, Kings Island; sponsor: Western Ohio Occupational Medical Association; cosponsor: American Academy of Family Physicians; 6 credit hours; contact: Alan Berenson, M.D., 2235 Langdon Farm Road, Cincinnati 45237, phone: 513/841-3773.

OUTCOME WORKSHOP: September 16-17; Bunts Auditorium, 9500 Euclid Avenue, Cleveland Clinic;

sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$500, \$250 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: toll free in Ohio 1-800-762-8172; outside Ohio 1-800-762-8173.

RECENT MEDICAL ADVANCES IN SURGERY: September 21; Marriott Hotel, 1414 S. Patterson Blvd., Dayton; sponsor: Wright State University School of Medicine; 6 credit hours; fee: \$75, \$60 for Wright State faculty, \$25 for health professionals; contact: Mary B. Fisher, Wright State University School of Medicine, Box 927, Dayton 45401, phone: 513/372-7140.

UPDATE IN OBSTETRICS AND GYNECOLOGY — 1983: September 21; Coliseum Holiday Inn, 4742 Brecksville Road, Richfield; sponsor: Aultman Hospital, Canton; cosponsor: Council of Chiefs of Ob/Gyn Northeastern Ohio Universities College of Medicine; 6 credit hours; fee: \$40, \$30 for residents and nurses; contact: Alvin Langer, M.D., Aultman Hospital, 2600 — 6th St., S.W., Canton 44710, phone: 216/438-6214.

ENDOMETRIOSIS: September 22-23; Bunts Auditorium, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$185, \$95 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll Free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

CARDIOLOGY UPDATE 1983: September 28-29; Bunts Auditorium, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$140, \$70 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: toll free in Ohio 1-800-762-8172; outside Ohio 1-800-762-8173.

October

INFECTIOUS DISEASE IN PEDIATRICS: October 5; Bunts Auditorium, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: \$60, \$30 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: toll free in Ohio 1-800-762-8172; outside Ohio 1-800-762-8173.

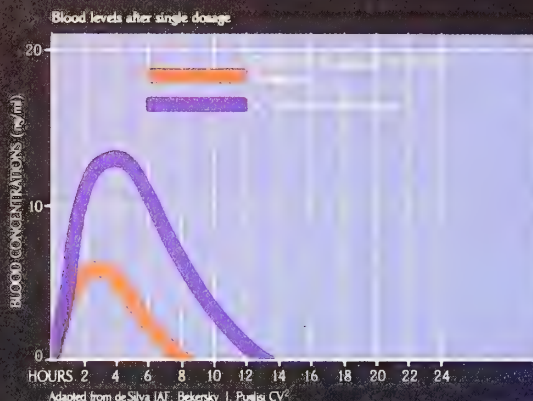
A FALL HARVEST OF CME: October 7-9; Sawmill Creek Lodge Resort, Huron; sponsor: Cleveland Clinic Educational Foundation; 15 credit hours; fee: \$180, \$90 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: toll free in Ohio 1-800-762-8172; outside Ohio 1-800-762-8173.

DERMATOPATHOLOGY SELF-ASSESSMENT WORKSHOP: October 8; Bunts Auditorium, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: \$80; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: toll free in Ohio 1-800-762-8172; outside Ohio 1-800-762-8173.

Second opinions advocated

The top auditor at HHS wants his agency to draft legislation requiring Medicare and Medicaid patients to get a second doctor's opinion before agreeing to elective surgery. Though others within the agency favor further study of existing second opinion programs, Inspector General Richard P. Kusserow says it's become obvious that voluntary ones curb little surgery but mandatory ones are big money savers.

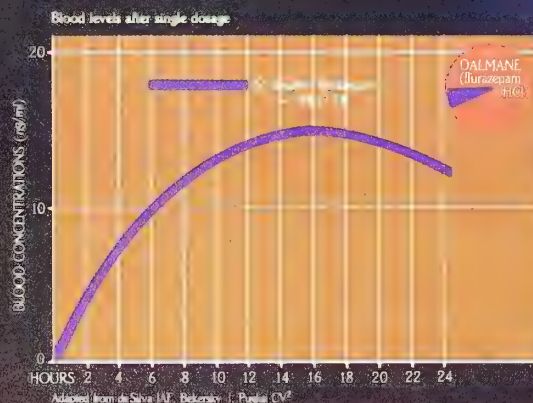
Only Dalmane® (flurazepam HCl/Roche) has the hypnotic profile that provides these benefits



The profile

Two short-half-life elements that appear rapidly
and are rapidly eliminated

The major active components of Dalmane are the parent agent flurazepam and its primary metabolite N₁-hydroxyethyl-flurazepam.^{1,2} These two compounds appear rapidly in the blood after ingestion, and they are eliminated quickly. Flurazepam has a serum half-life of approximately 2.3 hours. N₁-hydroxyethyl-flurazepam, which accounts for 22% to 55% of an average dose measured in urine, has a serum half-life of 2 to 3 hours.^{1,3}



A metabolite that
accounts for only 4% to 7%
of dose in plasma

Another metabolite of Dalmane—N₁-desalkyl-flurazepam—has a serum half-life of 47 to 100 hours.² This metabolite accounts for only 4% to 7% of an average dose measured in plasma.¹ It accumulates to steady state within 7 to 10 days,² and disappears gradually after discontinuation of therapy.

Only Dalmane offers the combination of a short-half-life parent agent, a short-half-life metabolite and a longer-half-life metabolite that diminishes slowly once therapy is discontinued. However, it is important to note that clinical assumptions cannot be made solely on the basis of pharmacokinetics or on one aspect of pharmacokinetics such as half-life.

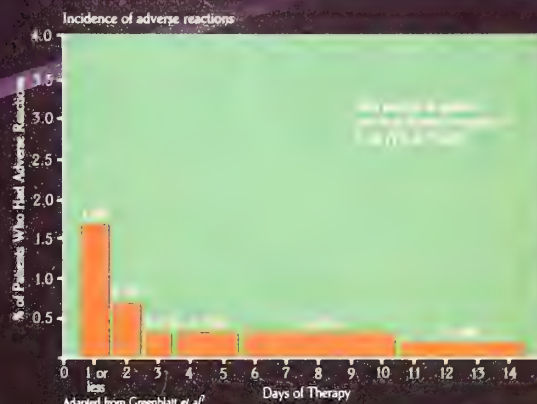
The benefits

**Dalmane (flurazepam HCl/Roche)
remains effective, yet rarely
causes morning hangover**

Sleep laboratory studies have repeatedly confirmed that Dalmane has unsurpassed efficacy in inducing and maintaining sleep.^{4,5} Dalmane reduced sleep latency by 44% on nights 1 to 3 of therapy and by 56% on nights 12 to 14—a level of continued performance unmatched by any other hypnotic tested.⁵ And Dalmane has shown an ability to reduce total wake time by a significant margin from the first night of therapy through 28 consecutive nights.⁴

Dalmane also rarely causes morning hangover.^{1,6,7} In one study of 2542 patients, the incidence of adverse reactions reported with Dalmane was only 3.1%. Most of the side effects occurred after the first night of therapy; the incidence declined as therapy continued.⁷ Thus, accumulation of the N₁-desalkyl-flurazepam metabolite of Dalmane is not associated with an increased incidence of morning hangover. But patients should be cautioned about driving or drinking alcohol during therapy. Because the risk of dizziness, oversedation and ataxia increases with higher dosages in the elderly and debilitated, the dosage should be limited to 15 mg in these patients. Dalmane is contraindicated in pregnancy.

Contemporary Hypnotic Therapy 



No rebound insomnia for up to two weeks

Rebound insomnia has been reported as a potential clinical problem on the first nights following withdrawal of certain benzodiazepine hypnotics.^{5,8} Yet with Dalmane there have been no reports of rebound insomnia for up to two weeks. In eight of eight sleep laboratory studies, patients showed no evidence of rebound insomnia on the first nights after Dalmane therapy was discontinued.⁹ Even on nights 12 to 14 following discontinuation of Dalmane, rebound insomnia had still not occurred in one study.⁴

Dalmane. The only hypnotic that consistently achieves all the goals of therapy: rapid sleep onset—a longer night's sleep—continued efficacy—low incidence of hangover—no rebound insomnia on the first nights after discontinuation.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. deSilva JAF, Bekersky I, Puglisi CV: *J Pharm Sci* 63:1837-1841, Dec 1974. 3. Kaplan SA et al: *J Pharm Sci* 62:1932-1935, Dec 1973. 4. Kales A et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 5. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977, and Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Gammerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 7. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 8. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 9. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981.



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See next page for summary of product information.

Obituaries

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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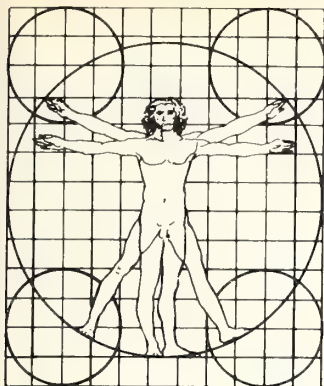
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PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY: EXPERIENCE WITH 75 CASES (PART II)

Ralph D. Lach, M.D.

Wayne L. Beaver, M.D.

Percutaneous transluminal coronary angioplasty now is being employed in hundreds of centers around the world. Indications and technics are changing rapidly. The authors describe their early experience with the technic with emphasis on both common and uncommon clinical situations as encountered in their series.

IN THE JUNE 1982 ISSUE of the Ohio State Medical Journal, we described the theoretical and early clinical background of transluminal angioplasty as developed by Gruntzig. Although Gruntzig had been performing balloon angioplasty of peripheral arterial lesions since 1974 in conjunction with other European investigators, his announcement of the first case of balloon angioplasty of a coronary artery was the stimulus for prompt world-wide attention to the concept of transluminal therapy and the adoption of this AMA style, the style we use in this country.

On December 5, 1979, the authors introduced the procedure at the Mount Carmel Medical Center in Columbus, Ohio. This was a case of angioplasty of a severely stenosed right coronary artery in a 51-year-old male with intractable angina.¹

Between that date and June 17, 1982, we have performed coronary angioplasty in 75 cases and peripheral angioplasty in 20 cases.

Reprint requests to 777 West State Street, Columbus, Ohio 43222 (Dr. Lach).

Acknowledgement: The authors are indebted to Ms. Bobbi Gankoski, RN, and Mrs. Jan Haren, RN, and their staff in the cardiac catheterization laboratory at Mount Carmel Medical Center. We also deeply appreciate the magnanimity and great skill supplied by the cardiothoracic surgical team of Drs. Ewy, Moore, Thomas, Sanfelippo, and Brahms. Without their full cooperation, this pioneering effort could not have been achieved. We also deeply appreciate the contributions of Patty Peters, RN, Judy Magas, RN, Connie Seal, RN, and Mary Nibert, RN.

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Submitted February 17, 1983.

Coronary Angioplasty

1. General Considerations and Method. Coronary angioplasty was performed in 58 males and 17 females according to the general protocol outlined by Gruntzig. The "ideal" candidate was identified as a relatively young patient with recent onset angina and a high grade proximal stenosis of a major coronary artery. Many of the patients presented with an episode of unstable angina or "limited necrosis" involving the region supplied by the stenosed vessel. With one exception, the patients were considered to be candidates for bypass graft surgery because of the amount of left ventricular muscle at jeopardy from the proximal lesion.

In the majority of cases, submaximal treadmill testing with Thallium₂₀₁ imaging of the left ventricle was achieved before and after angioplasty, usually within 48 hours. The absence of a perfusion deficit, despite the presence of a significant coronary lesion, frequently was relied upon to defer intervention. Similarly, the presence of a Thallium₂₀₁ perfusion defect was used as an important criterion to select patients for angioplasty when the perfusion defect was in the distribution of the involved artery.

In all cases, surgical concurrence was obtained and literal "standby" of cardiac surgeons, anesthesiologist, perfusionist and vacant open heart surgery suite were established prior to the initiation of each angioplasty. Detailed informed consent was obtained in all cases, initially under the direction of the Hospital's Institutional Review (research) Committee until the procedure was released by the Food and Drug Administration on March 28, 1980.

All cases were accomplished from a percutaneous right femoral entry, except the first case in which the brachial approach was utilized after an unsuccessful femoral approach due to limited availability of guiding catheters. Simultaneous femoral venous cannulation was used for placement of an electrode catheter for use as an anatomic marker and standby pacing device. Percutaneous insertion of an arterial line into a common iliac artery allowed constant monitoring of central aortic pressures. 9F guiding catheters were used to introduce the dilating balloon for the first 55 cases. (Now 8F guiding catheters have become available and are used preferentially.)

Patients were pretreated with ASA gr V bid and Persantine 75mg tid for three days before the procedure. Low molecular

weight Dextran infusion was started at 20cc per hour just prior to catheterization. Aqueous heparin was given in two 5,000-unit intravenous doses at the beginning of the procedure and just prior to insertion of the balloon catheter. The balloon catheter was filled with dilute contrast medium to facilitate visibility during the angioplasty. Simultaneous pressures were monitored closely from the tip of the guiding catheter, the balloon catheter and the iliac line.

An inflation device² was used to fill the balloon dilation catheter to a pressure of 4 to 9 atmospheres for 10 to 30 seconds at a time. Continued observation of the proximal and distal pressure allowed for identification of change in the translational gradient. Definition of success was in accord with that proposed by the PTCA Registry³ of the National Heart, Lung and Blood Institute; that is, an increase in distal pressure by 20mmHg or more and/or improvement in angiographic luminal diameter by 20% or more.

Unsuccessful angioplasty was followed by bypass surgery shortly after the procedure in virtually all cases because of the availability of the surgical team and consideration for the patient's psychological well-being. In no case in this series was "emergency" surgery necessary. Coronary spasm was treated with intracoronary nitroglycerin 100 to 200 micrograms, and in one case the balloon catheter was advanced through an apparent total occlusion of a right coronary artery which developed following the initial dilation. This maneuver was based on the work of Rentrop⁴ and was associated with persistent patency at seven months (Case No. 32).

Streptokinase was not used in any case in this group of 75 patients.

There were no procedure-related deaths in this series of 75 patients. There was one hospital death occurring 18 days after an unsuccessful attempt at angioplasty of a right coronary artery in a 66-year-old male with an abdominal aortic aneurysm.

Following his unsuccessful PTCA, he was taken to surgery where triple aortocoronary bypass graft surgery and resection of the abdominal aortic aneurysm were achieved. After an initially stable postoperative course, he developed evidence of intestinal obstruction necessitating laparotomy. Subsequently, bilateral femoral embolectomies were performed and sepsis supervened.

2. Results. The patient cohort consisted of 58 men and 17 women (Fig. 1). Five patients underwent repeat angioplasty after detection of restenosis following an initially successful angioplasty. The left anterior descending coronary artery was most commonly involved (48 cases). The right coronary artery was involved in 24 cases. The left main coronary artery was dilated in one case associated with multivessel disease (Case No. 32).

Following angioplasty, a hazy appearance frequently was noted in the region of the dilation (Fig. 2). An intimal flap frequently could be seen (Fig. 3), indicating some degree of "dissection" of the coronary artery, as previously described by Dorros and Spring.⁵

The overall success rate, as defined above, was 67%. Since this initial group was fairly homogeneous in selection, few specific subsets present themselves for analysis.

Cumulative success rates for left anterior descending and right coronary artery angioplasty are presented in Figure 4. The success rate as related to age and sex distribution is given in Figure 5.

A definite "learning curve" has been described⁶ which is evident in the results of various PTCA investigators. This generally consists of progressive improvement in success rates over the first several months of activity. Characteristically, however, with the achievement of greater experience and encouragement, all investigators⁷ have experienced a reduced success rate as they have attempted angioplasty in more difficult cir-

SITE OF DILATION		SUCCESSFUL	UNSUCCESSFUL	% SUCCESS
LAD	M	30	7	(35/48) 73%
	F	5	6	
	T	35	13	
RCA	M	10	8	(13/24) 54%
	F	3	3	
	T	13	11	
OTHER	M	2	1	(2/3) 67%
	F	0	0	
	T	2	1	
TOTALS	M	42	16	(50/75) 67%
	F	8	9	
	T	50	25	
LAD = Left Anterior Descending Coronary Artery RCA = Right Coronary Artery M = Males F = Females T = Total				

FIGURE 1. ANATOMIC AND SEX DISTRIBUTION ON THE FIRST 75 CASES OF PTCA.

cumstances (multivessel disease, previous aortocoronary bypass surgery, left mainstem disease, etc.). Many of their "more difficult" cases commonly represent patients with a similarly increased risk for open heart surgery such as advanced age, chronic pulmonary disease, other systemic disease, left ventricular dysfunction, previous thoracotomy, etc. In addition to the "learning curve," there have been more technological developments over time, which have resulted in improved results, analogous to technical modifications made in other medical procedures such as coronary artery bypass graft surgery. Figure 6 displays the results in the first ten cases in this series done between December 5, 1979, and September 9, 1980, and the last ten cases done between April 8, 1982, and June 17, 1982. Still on the horizon are further improvements in guiding catheters, balloon materials and different balloon systems. The newer "steerable" systems soon will be available.

3. Specific Case Results. While most cases revolved around simple considerations of success or failure, individual factors in selection, anatomy, and technic always were present. The following cases may illustrate their complex individual factors:

Case No. 32. M.E.W., a 54-year-old white female, was admitted to the Mount Carmel Medical Center for evaluation of chest pain. She had been hospitalized previously at her local hospital with chest pain "like indigestion." A severe stenosis of a very dominant right coronary artery was identified (Fig. 7A). Percutaneous transluminal coronary angioplasty was attempted with the conventional balloon catheter. This could not be passed through the stenosis and was replaced by a "low-profile" balloon catheter. This allowed successful dilation of the stenosis, though only to a 2mm size with a significant residual gradient (Fig. 7B).

At that time, it was considered inadvisable to "cross" the lesion again with a conventional catheter and the procedure was terminated. The patient then was readmitted November 20, 1982, for reassessment of the coronary lesion and probable repeat dilation.

The residual severe stenosis again was identified (Fig. 7C) and a conventional balloon catheter was passed through it. Several dilations were performed but, subsequently, the artery was found to be occluded (Fig. 7D) at the site of the lesion, probably due to spasm and/or clot formation. Intracoronary nitroglycerin and Nifedipine were unavailing. Severe chest pain and EKG evidence of acute ischemia were noted, including the appearance of ventricular ectopy.

While the surgery team was being mobilized, it was felt that mechanical recanalization should be attempted utilizing the balloon dilation catheter. This was, therefore, advanced through the area of occlusion (Fig. 7E) and immediate dilation resulted in a return of patency of the vessel. Several more dilations were applied. Surgery was again deferred.

Repeat coronary angiography on April 29, 1982, revealed a very minor stenosis (Fig. 7F) in the region of the original lesion (less than 30% narrowing).

Comment: Abrupt reclosure of a coronary artery at the time of angioplasty remains a feared complication. Direct mechanical recanalization occasionally may present a reasonable alternative to emergency surgery.

Case No. 45. G.R.B., a 54-year-old white male, presented on November 30, 1981, with progressive and extremely severe angina pectoris. Cardiac catheterization revealed left main stem stenosis (Fig. 8A) with multiple other coronary lesions and very poor left ventricular function with an ejection fraction of approximately 10% (Fig. 8B).

Because of the latter finding, the cardiac surgical consultant found him to be "inoperable."

Since his pain could not be controlled on maximal medical

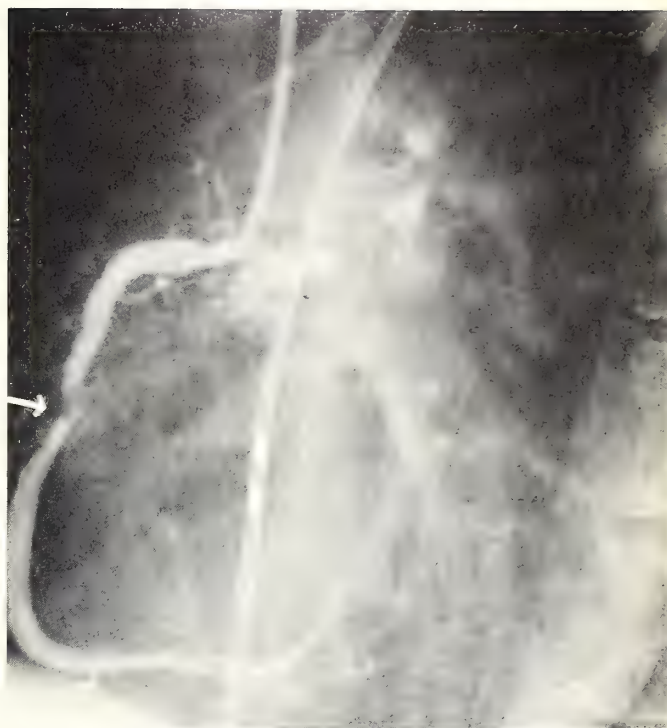


Fig. 2: G.C., 53 year old. Hazy appearance at site of right coronary artery stenosis immediately following angioplasty.



Fig. 3: E.C., 49 year old. Intimal flap indicating some degree of "dissection" of the coronary artery.

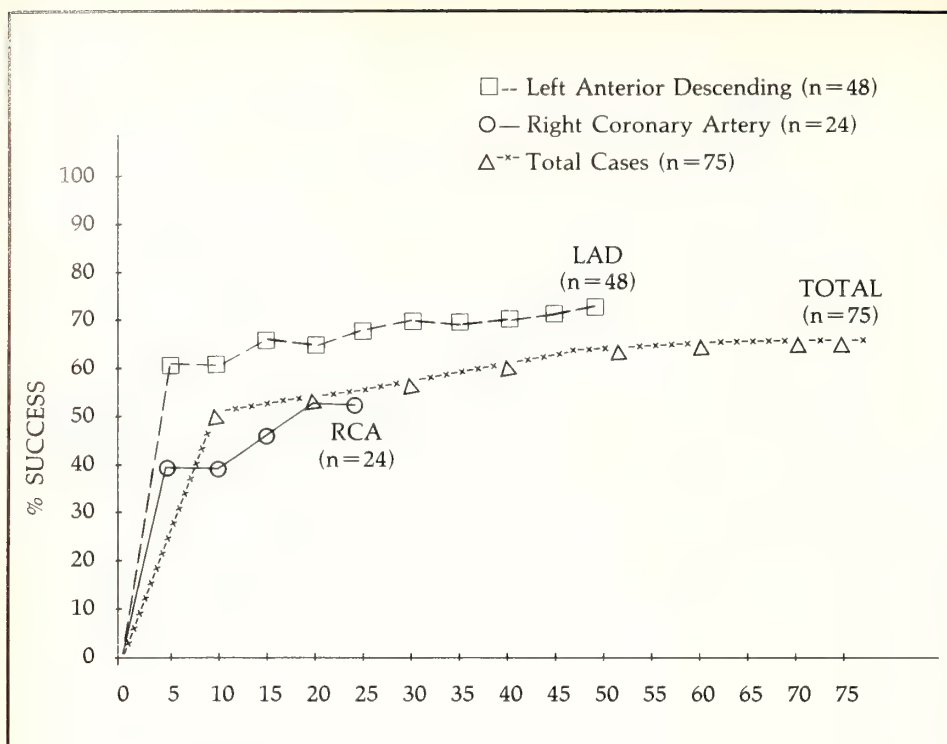


FIGURE 4. Cumulative success rate for PTCA.

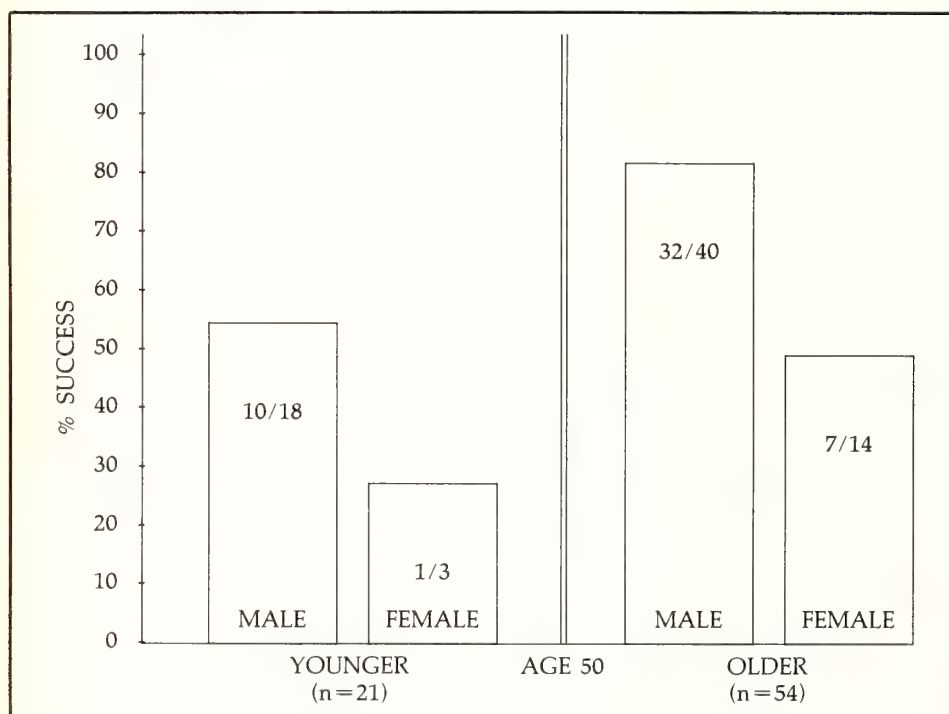


FIGURE 5. Success rate as related to age and sex distribution.

management, it was felt that a desperation attempt at dilation of the left main stem stenosis should be undertaken.

This was, therefore, carried out with considerable immediate improvement in the trans-stenotic gradient, accompanied by marked amelioration of his angina. He remained symptom-free for four months at which time his angina returned abruptly and severely.

Repeat angiography revealed restenosis of the left main coronary artery but the spectacular additional finding was improvement of the left ventricular function with an ejection fraction of 25% (Fig. 8C). Repeat dilation of the left main stem stenosis was carried out and, five days later, quadruple coronary bypass surgery was achieved without event. The patient has been essentially asymptomatic over the thirteen month follow-up since that time.

Comment: This very unusual case demonstrates the dynamics of myocardial ischemia and the necessity for close interaction with surgical colleagues.

Case No. 68. L.W., a 34-year-old white male, was admitted to the Mount Carmel Medical Center in May of 1982, with chest pain. EKG evidence showed evolution of limited necrosis of the anterior wall. Cardiac catheterization revealed an 85% stenosis of the proximal left anterior descending coronary artery with a trivial right coronary lesion and evidence of normal left ventricular function. Thallium₂₀₁ treadmill testing immediately before his angioplasty revealed normal exercise tolerance with no evidence of chest pain or electrocardiographic change. However, because of the clinical situation and coronary anatomy, coronary angioplasty was performed. A severe gradient was identified across the left coronary lesion, despite

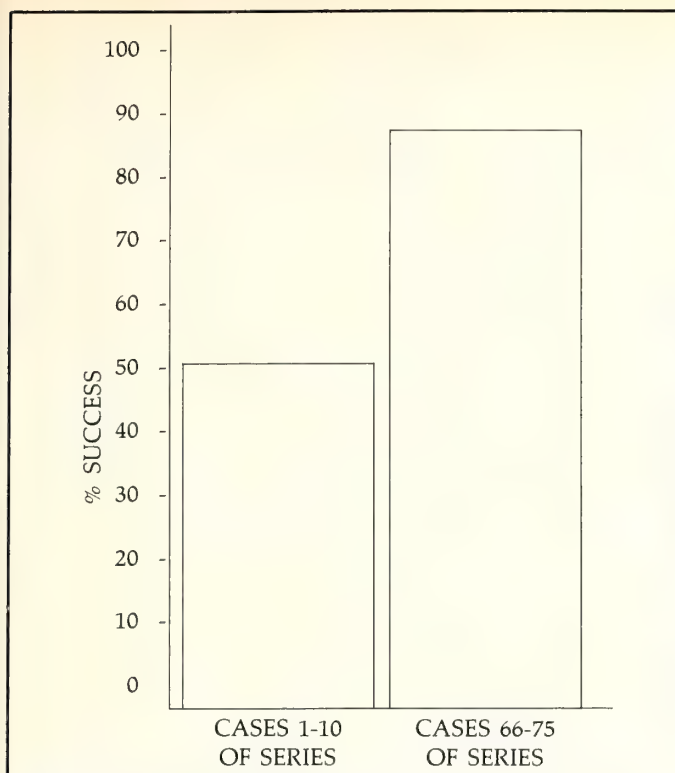


FIGURE 6. The "Learning Curve" of PTCA



Fig. 7A: M.E.W. — Right coronary artery angiogram prior to the first PTCA.

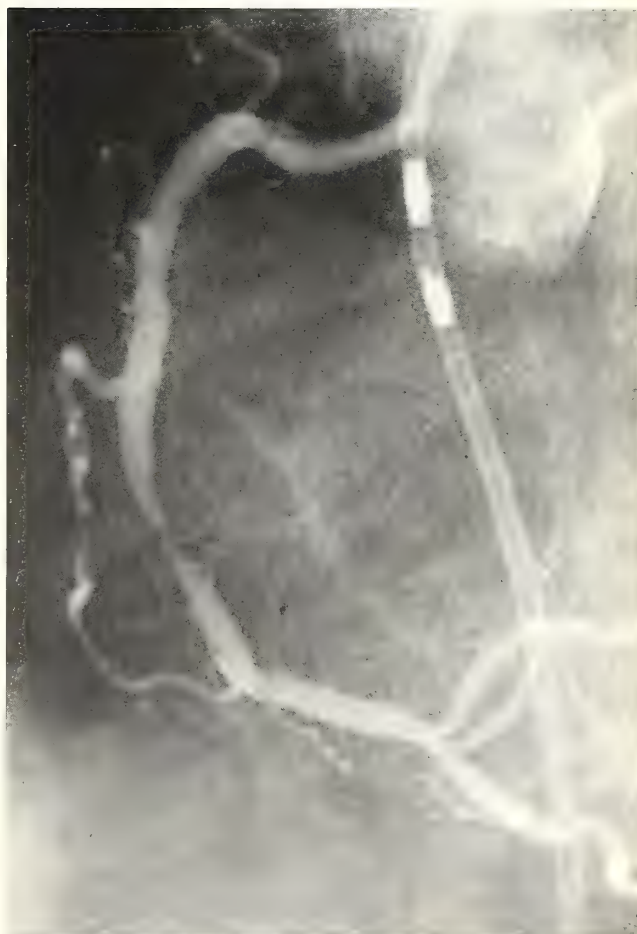


Fig. 7B: M.E.W. — Right coronary artery angiogram immediately after PTCA.

the negative exercise test and perfusion scan. The gradient was reduced from a mean of 55mmHg to a mean of 12mmHg (Fig. 9).

Post-PTCA angiography improved dramatically and the artery remained widely patent on repeat angiography six months later.

Comment: This discrepancy between radioisotope exercise testing and measurement of anatomic obstruction by determination of gradient, has not been previously reported, to our knowledge. However, "false negative" exercise testing has been recognized for some time. The routine measurement of coronary gradients is not currently recommended, however.

Discussion

The advent of "interventional cardiology" has brought with it new knowledge and new problems, in addition to the improved care of patients. PTCA already has brought to a very limited number of patients a definitive anatomic solution to their problems of obstructive coronary artery disease, without resorting to thoracotomy and coronary bypass. The attendant reduction in morbidity, expense, convalescent period and mortality is significant. Patients undergoing successful angioplasty can return to full normal activity in two or three days, including sports and manual labor. Complications generally are limited to minor local soreness in the region of the insertion of the femoral catheter. Mortality statistics accumulated by the PTCA Registry of the National Heart, Lung and Blood Institute consistently have shown a death rate of 0.6% (6 per 1,000). This appears to relate directly to the problems indicated above, with particular emphasis on the unique circumstance of patients with previous open heart surgery, now presenting with further manifestations of their coronary artery disease and/or graft failure. In this group, an acknowledged surgical problem is the increased morbidity and mortality of repeat bypass graft surgery. The same problem is encountered in occasional patients undergoing angioplasty who, when a serious

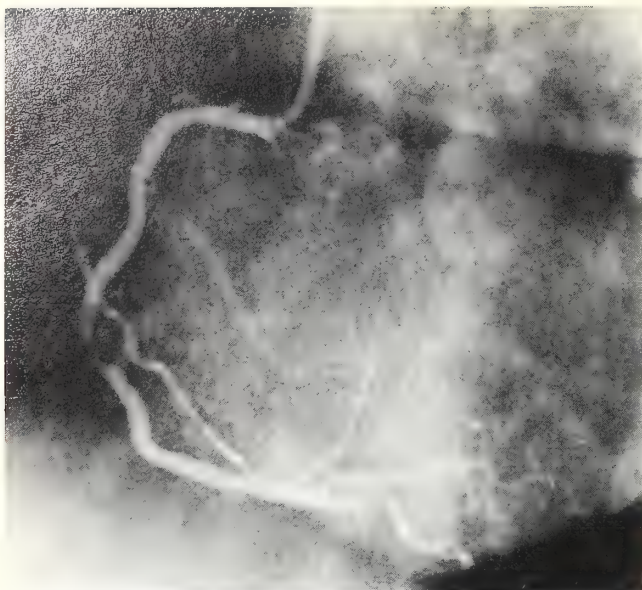


Fig. 7C: M.E.W. — Right coronary angiogram showing residual stenosis prior to second PTCA attempt.

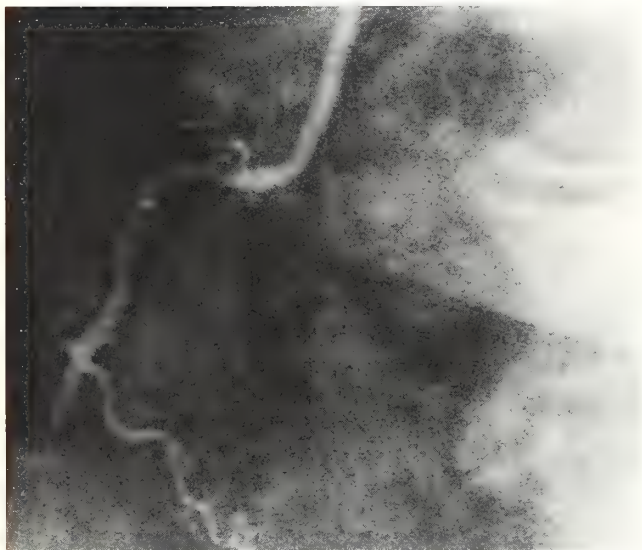


Fig. 7D: M.E.W. — Angiogram showing occlusion of Right Coronary Artery during second PTCA.

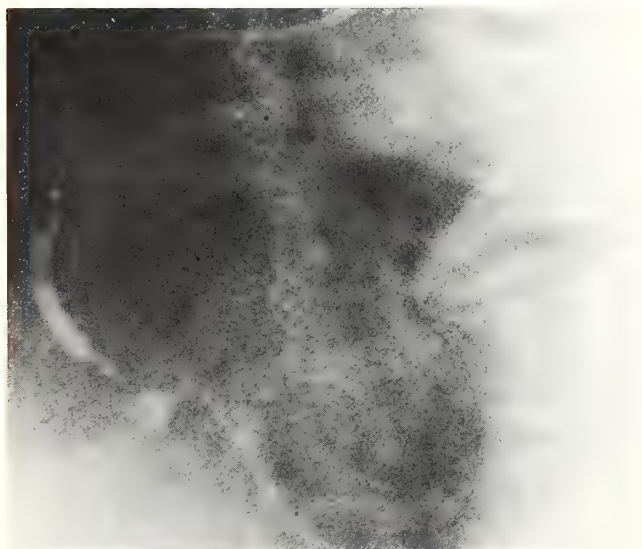


Fig. 7E: M.E.W. — Balloon advanced through the area of occlusion with immediate dilation to restore continuity of Right coronary artery.

complication appears, must go immediately to the surgical suite and must endure the technical risks associated with repeat surgery.

It should be clearly emphasized that PTCA is not a procedure to be taken lightly. Not only should it be attempted only in institutions with a very experienced catheterization laboratory team, but it must have the full and unreserved cooperation of an above average team of cardiac surgeons. These individuals must be able not only to perform complex open heart surgery but, on that very rare but inevitable occasion, to deal expeditiously with the patient whose PTCA has been complicated by coronary arterial spasm, dissection or clot, in order to avoid significant myocardial damage or other serious complication.

Finally, while coronary arteriography has come to be looked upon as a simple "routine" procedure, the similarities between arteriography and angioplasty end at the time of introduction of the guiding catheter into the arterial circulation. Cognizance of potential difficulties, complex manipulations of the catheter and balloon system and avoidance of various problems of potentially lethal import will depend directly upon the native skills and experience of the invasive cardiologist.

Addendum: Since the completion of the above analysis, an additional 75 PTCAs have been achieved with a greater success rate, including success in 26 of the last 28 cases. (93%)

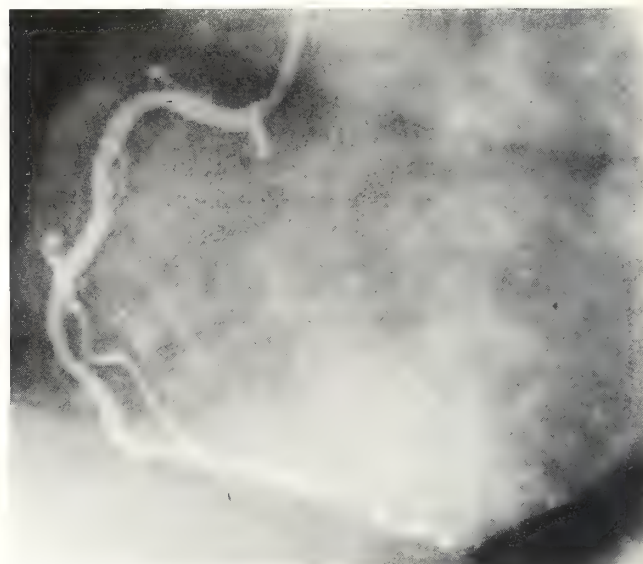


Fig. 7F: M.E.W. — Right coronary artery at followup 5 months post second angioplasty.



Fig. 8A: G.B. — Left main coronary artery stenosis.

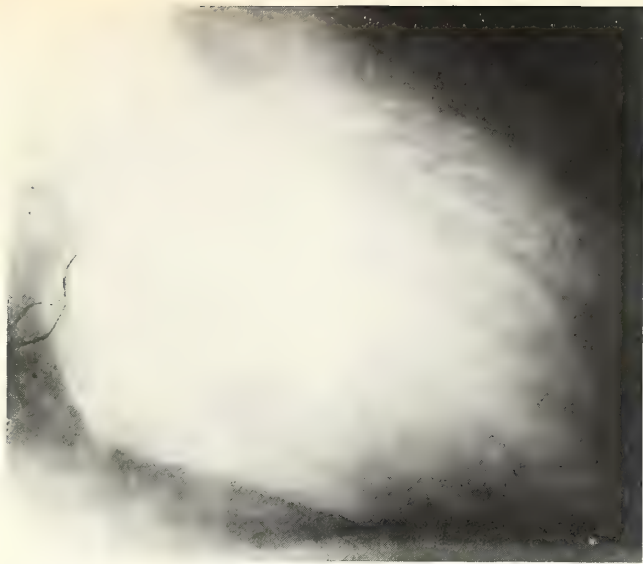


Fig. 8B: G.B. — End systolic frame of left venticulogram showing global hypokinesis of the left ventricle.



Fig. 8C: G.B. — Ejection fraction at the time of followup four months after the first PTCA, showing marked improvement in left ventricular function. The ejection fraction has increased from 10% to 25% as a result of left main coronary angioplasty.

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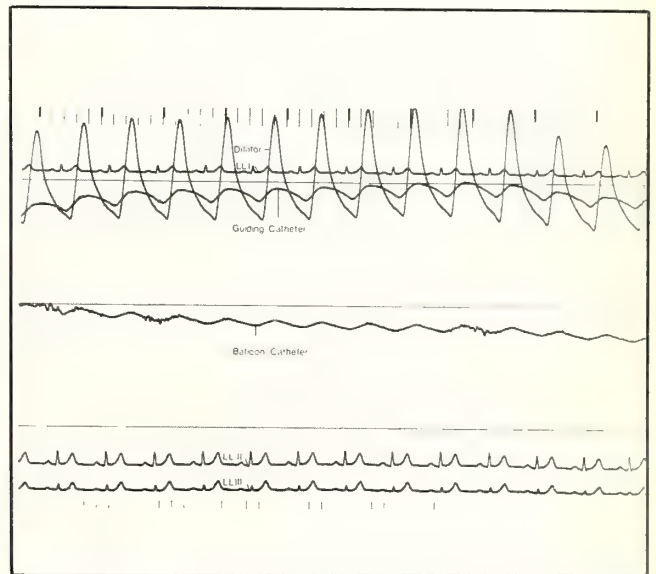


Fig. 9: L.W. — Pressure gradient recorded across coronary arterial stenosis in patient with negative thallium exercise study. Balloon catheter shows distal pressure. Guiding catheter shows pressure in proximal left coronary artery. Dilator shows pressure in systemic (left common iliac) artery.

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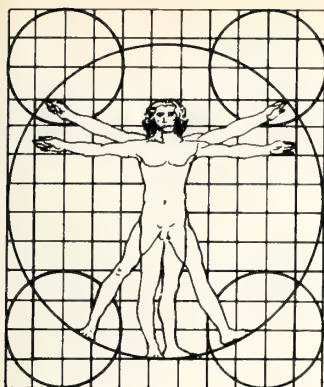
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CLINICAL & SCIENTIFIC

OCULAR CHANGES IN GRAVES' DISEASE

Joanne Pizzino, M.D.
James M. Falko, M.D.
James L. Moses, M.D.

The manifestations of thyroid dysfunction are many and varied. The terminology used to describe clinical findings often is confusing and misleading. This article deals with the ocular signs and symptoms of Graves' disease and some of the concepts relating to known histopathologic and biochemical changes associated with these findings. The term Graves' disease is used to encompass the ophthalmologic signs and symptoms of patients with presumed dysfunction centered on the pituitary thyroid axis. These patients may be clinically hyperthyroid, hypothyroid, or euthyroid.¹

Histopathologic and Biochemical Considerations

The thyroid gland secretes triiodothyronine (T3) and thyroxine (T4). These hormones act to control various aspects of systemic metabolism. The secretion of T3 and T4 is controlled by thyroid stimulating hormone (TSH) which is released by the pituitary gland. The pituitary gland is stimulated by thyroid releasing hormones (TRH) which respond to systemic levels of T3 and T4. The T3 suppression test has been used to determine aspects of thyroid dysfunction. This test is positive if administration of T3 fails to suppress 50% of the ¹²³I uptake by the thyroid gland. Most patients with Graves' ophthalmopathy demonstrate autonomous thyroid function as reflected by a positive test even if they are euthyroid biochemically. It also has been demonstrated that most Graves' patients do not release serum TSH from the pituitary gland after TRH administration. Thus, although peripheral blood thyroid hormone levels may be normal, these two tests can be helpful in making the diagnosis of euthyroid Graves' disease. Blood levels of T3 and T4 do not have a constant correlation with the development or course of Graves' eye changes. There also is not a direct relationship of long-acting thyroid stimulator (LATS) or other thyroid stimulating immunoglobulins (TSIs) to the ophthalmopathy, although they are found in a higher frequency in those patients who have ophthalmopathy. Although the etiology of the histopathology is unknown in Graves' ophthalmopathy, several lines of evidence suggest both cellular and humoral dysfunction. For example, there are several circulating antibodies found in plasma in Graves' disease patients including LATS, LATS protector, and human thyroid

stimulator (HTS).² These thyroid stimulating immunoglobulins are autoantibodies to normal thyroid constituents. An abnormal gamma globulin (not LATS) may be an obligatory serum factor for binding of antibody to antigen.² Membranes from orbital muscles have a much greater affinity for thyroglobulin/antithyroglobulin immune complexes than membranes from other tissues supporting a possible immune complex process.³

Patients with Graves' ophthalmopathy also have cellular-mediated dysfunction. The migration inhibition factor (MIF) test has been used to substantiate involvement of cell-mediated abnormalities in patients with exophthalmos, whether hyperthyroid or euthyroid. Thus, Graves' patients may manifest a positive MIF test to human retro-orbital muscle antigen.

A proposed exophthalmos-producing substance (EPS) has been implicated in Graves' ophthalmopathy. This factor consists of both the beta chain of TSH and 50 amino acids of the alpha chain. Attachment of EPS is enhanced by adding ophthalmogenic immunoglobulins (O-Igs).³ However, there is no evidence that this substance plays any role in human exophthalmos.

The histopathologic and biochemical changes seen in the orbit of Graves' disease patients include increased mucopolysaccharide and water, connective tissue, and mast cell proliferation. There is lymphocytic and chronic, inflammatory cell infiltration and an increase in orbital fat content.² Edema and degenerative changes occur in the extraocular muscles. Muscle fibers show loss of striation. Increased secretory activity by fibroblasts seems to be responsible for orbital involvement, but

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the stimulus for this still is unclear. Receptors sensitive to TSH exist on adipocytes, harderian gland membranes, blood polymorphs, and monocytes.

Clinical Characteristics and Evaluation

From a clinical standpoint there are many ocular, orbital, and adnexal findings associated with Graves' disease. Exophthalmos may affect both globes but is frequently unilateral. The degree of exophthalmos is commonly asymmetric. The prominence of the protruding globe often is accentuated by lid retraction and lid lag. Early lid retraction which may affect both the upper and lower eyelids probably is mediated by the sympathetic nervous system. Topical Guanethadine can re-

verse some of the lid retraction and lid lag. Conjunctival vascular congestion and edema may be seen. Injection overlying the insertion of the extraocular muscles is common. Infrequent blinking with an associated stare phenomena may produce conjunctival and corneal exposure changes leading to corneal erosion and possibly ulceration. Because of the prominence of the globe and the poor coverage, patients may complain of a foreign body sensation, a feeling of pressure, and photophobia. Corneal changes may decrease vision. Serious loss of vision may be seen in association with compression of the optic nerve by adjacent extraocular muscles. This is particularly common in the region of the orbital apex. In 1977 Werner revised his classifications of ocular findings in Graves' disease.⁴ The acronym NO SPECS may be used to remember the signs and symptoms of the classification.

CLASS	SIGNS OR SYMPTOMS
0	None
1	Only signs, no symptoms
2	Soft tissue involvement with signs and symptoms
3	Proptosis of 3mm or more with or without symptoms
4	Extraocular muscle involvement
5	Corneal involvement
6	Sight loss

Classes 2 through 6 portend a worse prognosis.

In class 0 the patient may demonstrate systemic signs of thyroid dysfunction but does not have any ocular signs or symptoms. In class 1 only signs are present but the patient is asymptomatic.

In class 2 the patient may complain of a foreign body sensation, photophobia, and tearing as well as local lid irritation. Pigmentation of the upper eyelids, conjunctival congestion, and enlargement of the lacrimal gland may be seen.

Prominent proptosis (exophthalmos) is present in class 3 ophthalmopathy. This may or may not be symptomatic. Greater than 50% of all exophthalmos cases are associated with an endocrine disorder. This includes about 25% of cases of unilateral exophthalmos and approximately 90% of all bilateral exophthalmos.⁵ Exophthalmos is found at any age but is most common in females with the onset of hyperthyroidism about the age of 25.⁶ The globes are difficult to repulse into the orbits. An exophthalmometer can be used to measure the amount of proptosis. This can be used for baseline documentation as well as evaluation of the progression of the disease. Though readings of 18 to 20 mm beyond the lateral margin of the orbit usually are considered abnormal, it should be remembered that there may be baseline differences existent between races or individuals with anomalous orbital anatomy.

Also seen in class 3 is an entity known as malignant exophthalmos. This rapid protuberance of the globe may develop within a period of days. There is an increase in the intraorbital pressure. This may be associated with compression of the optic nerve with associated loss of vision.

Extraocular muscle involvement of class 4 may result in diplopia, especially vertical diplopia. Diplopia is more likely in extremes of gaze. Though all extraocular muscles may be involved with a thyroid dysfunction, the inferior rectus muscle is the most commonly involved. This may result in decreased up gaze. The muscle involvement may be secondary to acute swelling and edema or secondary to later fibrotic changes. The intraocular pressure may elevate on up gaze. This sign is exquisitely sensitive for extraocular muscle fibrosis. Extraocular muscle dysfunction may be associated with paralysis. Therefore, it is important to consider other etiologies for diplopia

such as myasthenia gravis. The combination of thyroid ocular disease and myasthenia may account for bizarre combinations of muscle tightening and weakness. Noteworthy is that these two diseases occur in greater frequency with each other.

In class 5, corneal involvement results from exophthalmos, infrequent blinking, lagophthalmos. Also, corneal and lacrimal metabolism may be impaired. Early findings of superficial punctate staining may be seen on slit lamp evaluation. The mid and inferior portions of the cornea most commonly are involved. Corneal ulceration may be a severe sequela to chronic exposure changes.

In class 6, loss of vision may result from corneal changes or optic nerve compression with associated edema and atrophy. Orbital circulation is impaired. The optic disc may be edematous and later atrophic. Edema of the retina, retinal hemorrhage, venous engorgement and retinal folds may be seen.

It should be noted that many patients have varying combinations of findings in two or more classes. Also, many of the above findings may be seen with multiple other ophthalmologic entities. Exophthalmos may be seen with multiple orbital, sinus and metastatic tumors, granulomas of the orbit, vascular and bony abnormalities, anomalies affecting the orbit, liver cirrhosis, Cushing's syndrome, and acromegaly. The impression of exophthalmos may be given if the opposite eye is enophthalmic as well.

Though the diagnosis of Graves' ophthalmopathy is often a clinical one, the diagnosis and continued evaluation of aspects of the ocular and orbital involvement may be determined utilizing various laboratory studies. Computerized tomography (CT) of the orbit as well as orbital ultrasonography often demonstrates the characteristic evidence of dysthyroid involvement. The most constant and important sign noted is enlargement of the extraocular muscles. This may be mild or enormous in proportion. With the ability to resolve other orbital structures, compression of the optic nerve at the orbital apex can be seen. CT scanning in the coronal plane may demonstrate changes in all four rectus muscles simultaneously whether one or both orbits are affected clinically. Bony changes may be seen in the thin medial wall of the orbit. This is due to constant pressure on these orbital structures.⁷

Treatment

There are multiple treatments for the ocular findings of Graves' disease. These depend upon the systemic condition of the patient as well as the presence of varying combinations of ocular signs and symptoms. For the patient's well being, attempts at producing a euthyroid state are very important. It is important to note that the ocular findings in thyroid disease may be present in the euthyroid state as well as in hyperthyroidism and hypothyroidism. The systemic treatment of the generalized thyroid disorder may improve or worsen the ophthalmopathy. This is true with medical as well as surgical treatment. For example, in those patients who are hyperthyroid, recent theories relating to the exacerbation of the ophthalmopathy after I^{131} or surgery include an increased release of thyroglobulin-antithyroglobulin immune complexes in the bloodstream, a spontaneous change in the course of disease, or a transient effect of hypothyroidism. On the other hand, in hypothyroid individuals, replacement therapy may improve symptoms and signs. Systemic treatment of various components of dysthyroid ophthalmopathy may be beneficial for the acute signs, especially optic nerve involvement. Dosages of 100 to 150 mg of prednisone daily for one to two weeks with gradual tapering with stabilization is recommended.^{8,9} Cytotoxic agents with or without steroids have been used in a few patients with variable results. Supervoltage radiation has been utilized with reasonable success. A total of 1,500 to 2,000 rads in divided doses directed to the orbital apex has been advocated.^{10,11} Surgery may be indicated for several reasons. These relate to eyelid changes, corneal exposure, extraocular muscle involvement, or optic nerve involvement, or a combination of any of the previously mentioned problems. The surgery may be emergent for the decompression of the orbit or coverage of the cornea. Surgical procedures may be elective or cosmetic in nature. Extraocular muscle surgery commonly is done after there is stabilization of the fibrosis of the extraocular muscles. The surgery involves maximal muscle recession and/or an adjustable suture. Various eyelid surgical procedures are possible. They may be directed to the removal of excessive periorbital tissues, relaxation of the muscles producing the lid retraction or fusion of the lid margins to provide better protection for the cornea. Eyebank scleral implantation in combination with levator recession may be performed to provide for more lasting effects on relaxation of eyelid retraction.

Orbital decompression may be necessary to diminish proptosis as well as to relieve the pressure on the optic nerve and other orbital tissues. Various types of orbital decompression surgery can be performed. This may be performed via various approaches to the orbit. Essentially, the decompression of multiple walls of the orbit provides for better relaxation of the orbit. More posterior decompression in the area of the medial wall of the orbit is done to relieve medial rectus pressure on the optic nerve.¹² Often this is done through a Caldwell-Luc approach. Excellent relaxation of the orbital contents with minimal scarring and better exposure of the surgical field can be seen with an inferior fornix orbitotomy in combination with a lateral canthotomy.^{13,14}

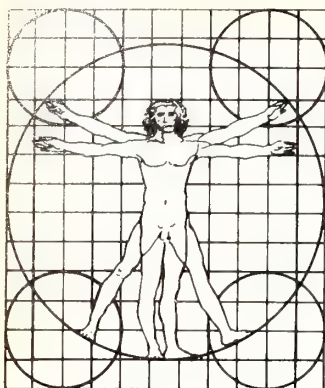
The many problems encountered with Graves' disease present a challenge to multiple disciplines within the field of medicine. Hopefully, improved prognosis will be realized with advances in immunology and biochemistry. Increased sophistication with computerized tomography of the orbit as well as orbital ultrasonography will improve the diagnosis and management of many of the problems that have been described.

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CLINICAL & SCIENTIFIC

EXPERIENCE IN PRIVATE PRACTICE WITH THE IMPLANTABLE ARTIFICIAL URINARY SPHINCTER

Herbert William Riemenschneider, M.D.
Stephen G. Moon, M.S.

The private practitioner of urology can transfer investigational technology to the practical application of patient care. The 791/792 semiautomatic artificial urinary sphincter has been used in this context in the incontinent male since December 1979. Significant success has been achieved with the device. These encouraging results depend on careful preoperative patient selection. Sixteen patients have been implanted. The surgical technic and clinical experience is reviewed.

"I have regained my dignity, I don't have to hide anymore, and I feel useful." These are the comments of a man who had been incontinent of urine after radical cancer surgery and now is dry as a result of implantation of the artificial sphincter.

Many different diseases can cause urinary incontinence. The urinary tract pathology must be studied carefully and understood. If this is done, we can select patients and cure their incontinence with the artificial sphincter.

The 791/792 artificial urinary sphincter consists of a balloon pressure reservoir, inflatable cuff, control assembly, and pump (Fig. 1). The control assembly is the heart of the device. Fluid is transferred from the cuff into the balloon when the pump is compressed. The cuff is refilled by the pressurized fluid in the balloon reservoir. The refilling is delayed by a resistor in the control assembly long enough for voiding to occur.¹

The reservoir pressure determines the amount of "squeeze" produced by the cuff. The pressure is correlated with the blood pressure in the urethra or bladder wall so the cuff will not cause necrosis. Continence results from a balance of expulsive force and outflow resistant force. The device is used to produce the minimal cuff squeeze necessary to bring these forces into balance. Patients from a general urologic practice were implanted and studied. A review of clinical results from the group form the basis of this report.

Patient Selection

Sixteen patients had severe urinary incontinence. Ten had had radical prostatectomy, two transurethral resection, one retropubic prostatectomy, one abdominal perineal resection of the colon, and two spinal cord injury. They were evaluated with history, physical examination, intravenous pyelogram, cystoscopy, uroflow, cystometrogram, urinalysis, culture and sensitivity, and measurement of penile blood pressure.

Fourteen patients had an incompetent sphincter mechanism and a normal bladder. Two had a neurogenic hyperreflexic bladder and one of these had a dyssynergic obstructive external urethral sphincter. The hyperreflexic bladders were treated with drugs or sacral rhizotomy. The obstructive sphincter was incised transurethrally. All patients, when implanted, had normal bladder capacity and a nonobstructive outflow tract.

Method

An appropriate balloon reservoir is selected based on the principle that the pressure generated is below the blood pressure in the bladder neck or urethra. The 792 device is used when the cuff is placed at the bladder neck (Fig. 1). The implant is done through a low transverse abdominal incision. The endopelvic fascia lateral to the prostate is incised and a space is dissected between the posterior bladder wall and the seminal vesicles (Figs. 2A and 2B). An appropriate sized cuff is secured around the bladder neck (Fig. 2C). The balloon reservoir is placed in the perivesical space. Tubes from the balloon and cuff are passed through the posterior wall of the inguinal canal. The pump is placed in the scrotum and the tubes are connected to the control assembly (Fig. 3).

The 791 device is used when the cuff is placed around the urethra (Fig. 1). The proximal bulbous urethra is exposed through a midline perineal incision (Fig. 4A). A passage is developed around it using the cutter clamp (Figs. 4B, 4C, 4D, and 4E).² Endoscopy is used to be certain the urethra is not lacerated. An appropriate sized cuff is placed and secured (Fig. 4F). The cuff tubing is passed subcutaneously to a small inguinal incision. The spermatic cord is retracted and the posterior wall of the inguinal canal is punctured (Fig. 5A). The reservoir is placed in the intra-abdominal extraperitoneal space (Fig. 5B). The control assembly is located in the subcutaneous inguinal space (Fig. 5C). The pump is placed in the scrotum and appropriate tubing connections are made (Fig. 6).

Primary deactivation is the technic whereby the device components are implanted but the cuff is not pressurized.³ The connections are made after six to twelve weeks and the device

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Submitted December 4, 1981.

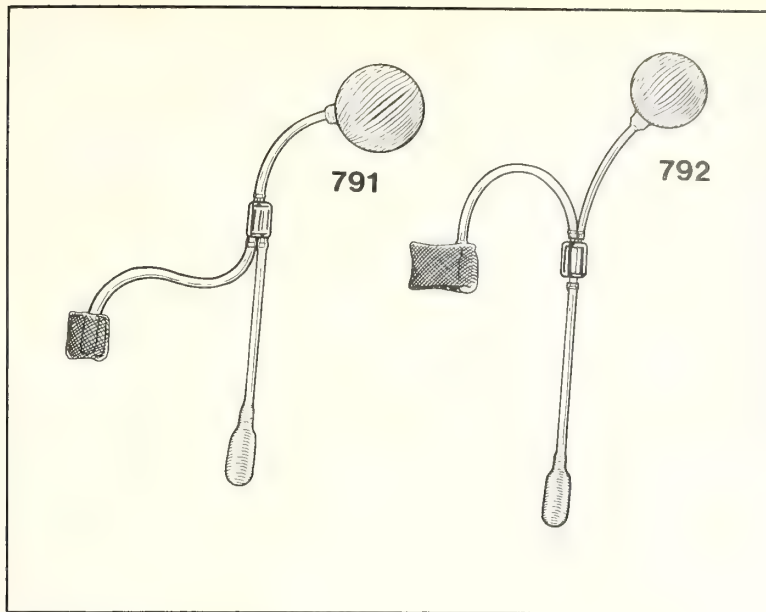


FIGURE 1.

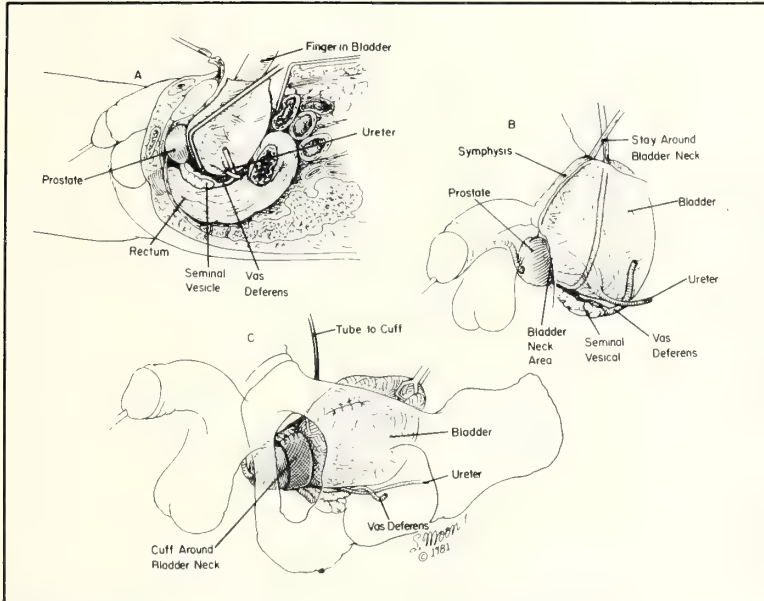


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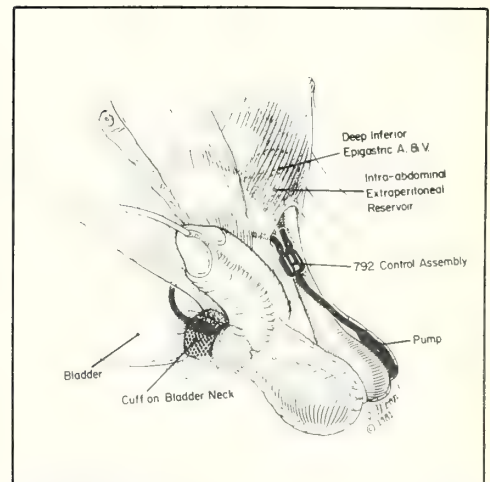


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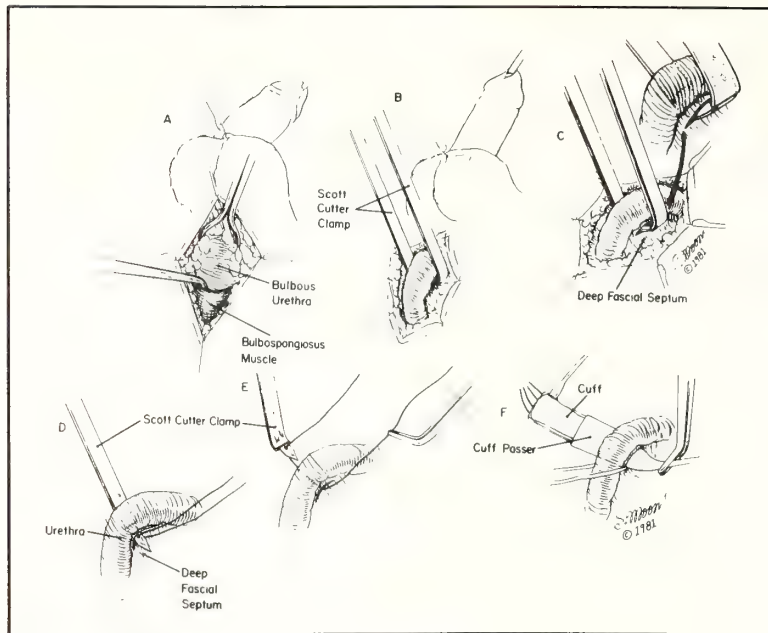


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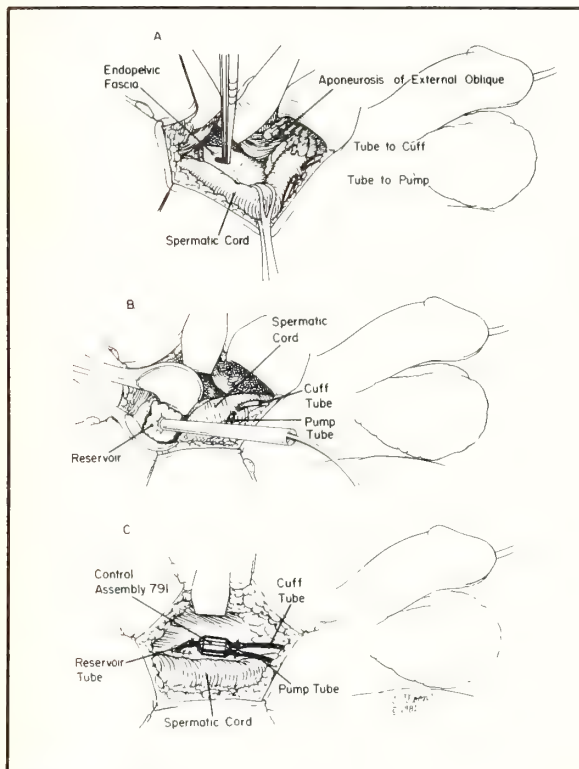


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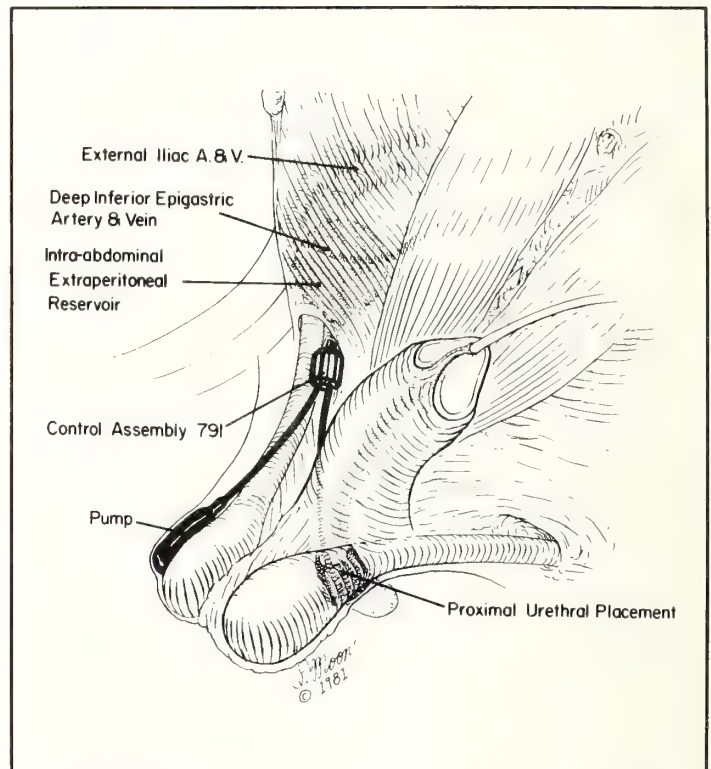


FIGURE 6.

is activated. This method provides time for revascularization of the dissected urethra or bladder neck. It probably increases urethral tolerance to cuff squeeze possibly avoiding erosion.

Results

Success is the situation in which the patient is dry between voiding, empties the bladder so that the residual urine is less than 100 cc, has unchanged or improved upper tracts, and has no complications for more than 90 days. Qualified success is similar except he wears a pad for security but never requires more than one a day. Failure is when the patient is no better than before implantation or has to use more than one pad a day. A patient currently continent but less than 90 days following implantation is classified as an unknown result (Fig. 7A).

In this series, there are eight patients with success or qualified success for greater than 90 days and of these, six patients are 12 months or more postoperative (Fig. 7B). Five patients are currently continent, less than 90 days postoperative and are classified as an unknown result. Three patients have had irreparable failures.

Four patients had urethral erosion at the site of cuff placement. Two of these were salvaged by another implantation using "primary deactivation." The third failure occurred in a neuropathic bladder when unstable detrusor contractions could not be suppressed. All failures occurred within 90 days of implantation.

The erosions occurred when the cuff was placed around the urethra. These patients had systolic penile blood pressure less than 70 mm of mercury, two had previous urethral surgery, and one had prior urethral irradiation. Patients with systolic penile blood pressures greater than 70 mm of mercury have not had erosion to date. In summary, there is 50% success or qualified success, 31% unknown results, and 19% failure.

Discussion

It is clear that implant patients who are continent without

complication for 90 days have a good chance for long-term success. Patients with a normal bladder and an incompetent sphincter are the most likely to have good results.

The major complication encountered in this series is urethral erosion. This problem frequently occurred in patients with poor urethral circulation such as those with low penile blood pressure, pelvic and urethral irradiation, or prior urethral surgery.

Patients with any of these problems should be implanted using the technic of "primary deactivation" and a device with a low balloon pressure. These patients should be forewarned that they may endure some postoperative stress incontinence. The device cannot be used in patients when the bladder neck is not accessible for cuff placement and urethral circulation is very poor.

The 791/792 artificial sphincter is applicable to some patients with urinary incontinence; when the patients and implant technics are carefully selected, it is the best treatment alternative currently available. The success rate of 50% in this series should improve as experience increases.

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A			
SUCCESS — DRY > 90 DAYS			
QUALIFIED SUCCESS — DRY > 90 DAYS USING 1 PAD A DAY			
FAILURE — WET OR USING > 1 PAD A DAY			
UNKNOWN RESULT — DRY < 90 DAYS			
B.			
SUCCESS	MONTHS	QUAL. SUCCESS	MONTHS
B.W.	3	B.F.	3
N.L.	13	R.S.	12
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FIGURE 7.



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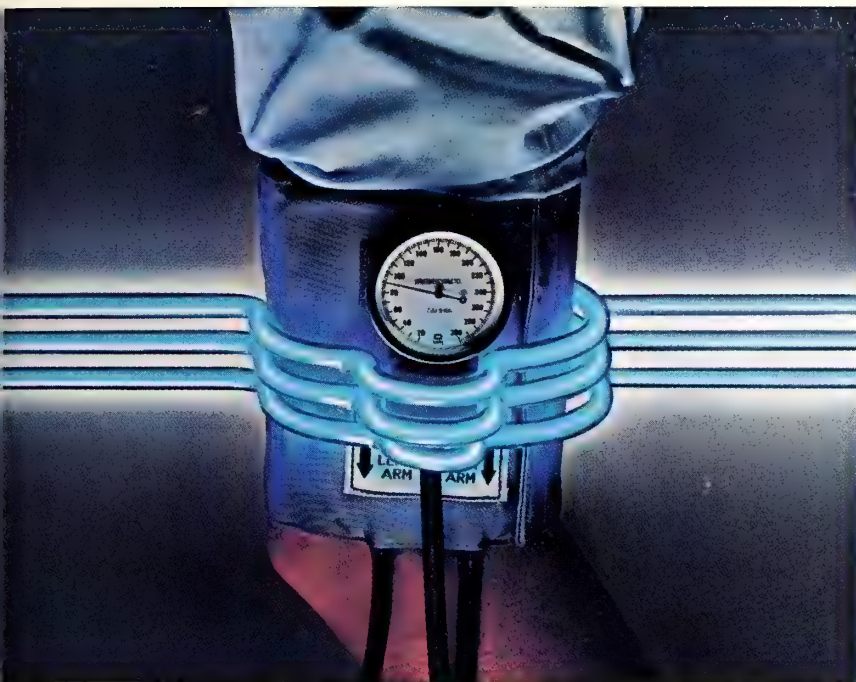
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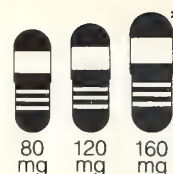
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Inderal LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pia vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Inderal (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block, hypotension, paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of Inderal LA capsules is a registered trademark of Ayerst Laboratories.

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Waning interest in antihistamine therapy

Enthusiasm for antihistaminic therapy has waned dramatically since the substances were introduced in the mid-1940s. Where 95 percent success in gaining symptomatic relief was once claimed, it now appears that closer to 35 percent is realized.

Forty years later, investigators are working on new methods to protect patients from histamine, which causes hives, asthma, and other allergic reactions, says Walter B. Shelley, M.D., Ph.D., a researcher at the University of Illinois College of Medicine in Peoria, who writes in a recent issue of the *Archives of Dermatology*.

Shelley says that new research efforts center on blockage of receptors for certain antibodies on mast cells, and on the development of a whole new class of "antiphosphoryl cholinergics" (substances involved in inhibiting certain nerve fiber reactions).

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Preventing Patient Abuse of Drugs

By Rebecca J. Doll

Not nearly as dangerous, but abused nonetheless, are certain over-the-counter drugs, such as aspirin, nasal sprays and cough syrup. Patients should be cautioned about the abuse of these substances as well.

"Take two aspirin and call me in the morning," goes the old adage from doctor to patient. Years ago, that was just about all a doctor could do. But, fortunately, today's patient can look forward to relief from pain and sickness, thanks to a vast array of drugs and medications.

Not so fortunate, however, is the fact that many patients, for various reasons, abuse and misuse them. Physicians can contribute greatly to preventing this abuse and misuse by making certain patients understand the dangers associated with improper use of drugs and by helping patients to understand as much as possible about the drugs they are taking. One of the best ways to do this is to supplement verbal instructions with written instructions.

Written instructions to patients should include:

- the name of the drug
- amount to take
- when to take it
- side effects if any
- what to do if side effects do occur
- foods or other medications which should be avoided
- warnings against taking the drug with alcohol or when driving
- how long to continue taking the drug

Written instructions can be especially valuable to elderly patients who may forget or misunderstand verbal instructions.

The American Medical Association, through its Patient Medication Instruction (PMI) program, has available a series of patient instruction sheets on various drugs and drug classes. Sample copies of the PMIs are available through the OSMA Department of Communications.

Not nearly as dangerous, but abused nonetheless, are certain over-the-counter drugs, such as aspirin, nasal sprays and cough syrup. Patients should be cautioned about the abuse of these substances as well.

In addition to written instructions regarding a specific drug, you may want to offer your patients general information on the health dangers of alcohol and drug abuse. Included should be information on appropriate storage and disposal of outdated medications.

Patients should be reminded to:

- clean out their medicine chests at least once per year, disposing of any drugs which are past the expiration date printed on the label
- dispose of any medications that seem to have changed in color, smell or consistency
- dispose of antibiotics and prescription drugs after the need for them has subsided, unless instructed otherwise
- keep drugs in a cool, dark environment away from extremes of heat and humidity, unless instructed otherwise
- always keep drugs in their original containers
- keep track of purchase dates on drugs

Physicians can help prevent drug abuse by:

- prescribing no greater quantity of a controlled substance than is needed until the next checkup
- making prescription orders as alteration-proof as possible and using a separate prescription blank for each controlled substance
- avoiding the use of prescription blanks that are preprinted with the name of a proprietary preparation
- refusing to bow to pressure from patients for additional or increased levels of drugs
- safeguarding supplies and keeping accurate records of prescribed drugs
- staying abreast of current literature on therapeutic advances. **OSMA**

The benefits

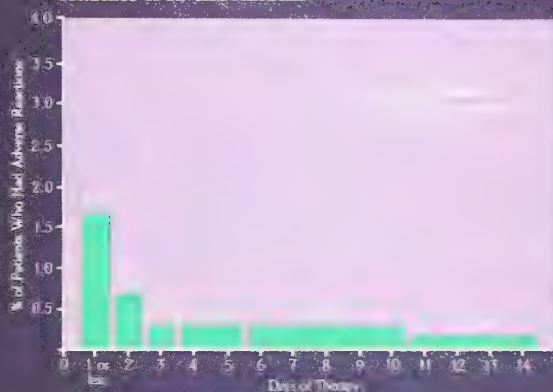
Dalmane (flurazepam HCl/Roche) remains effective yet rarely causes morning hangover

In objective sleep laboratory studies, Dalmane proved more effective than any other hypnotic tested.^{5,6} Patients with insomnia fell asleep 44% sooner on the first three nights of Dalmane therapy and 56% sooner on nights 12 to 14.⁶ Total wake time decreased significantly on the first nights of therapy, and tolerance did not appear to develop for up to 28 consecutive nights of treatment.⁵ Even after four weeks, Dalmane was still significantly more effective than placebo or other hypnotics, some of which lose effectiveness on chronic dosing.^{5,7}

Morning hangover, moreover, was rare with Dalmane. In a study of 2542 patients treated in the hospital, only 3.1% reported adverse reactions after Dalmane treatment. Most of the side effects occurred after the first night of treatment; the incidence diminished as therapy continued.⁸

Caution patients about driving or drinking alcohol during therapy. Because the risks of dizziness, oversedation and ataxia increase with higher dosages in the elderly and debilitated, the dosage should be limited to 15 mg in these patients. Dalmane is contraindicated in pregnancy.

Incidence of adverse reactions



Adapted from Greenblatt et al.⁸

And Dalmane (flurazepam HCl/Roche) avoids rebound insomnia

If patients sleep worse when medication is discontinued than they did before treatment began, the value of hypnotic therapy is clearly questionable. Such rebound insomnia has been reported with certain hypnotics that have short half-lives.^{9,12} Yet this problem does not occur with Dalmane as proven in eight of eight sleep laboratory studies.¹¹ Even after two weeks following discontinuation of Dalmane, rebound insomnia had not occurred.⁵

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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S. Baird Pfahl, M.D.

PRESIDENTIAL PERSPECTIVES

Do You Know What a Stinger Is?

By S. Baird Pfahl, M.D.

As an inveterate "jock," I ask that you join me in sharpening our medical skills in the field of sports medicine.

In ten years of organized football, I received care that we know now was not adequate. A real leather helmet in high school and no water during practice in hot, or any other, weather. Heat was used for bruises and everything else that was not wrapped. Still,

sability and encouragement of sports medicine specialists such as John Bergfeld, M.D., of the Cleveland Clinic (a man whom, I feel, can walk across Lake Erie *in the summer*) and other equally talented physicians, I became a team doctor.

What a challenging, rewarding and exciting experience this has been for me, and the other volunteer physicians

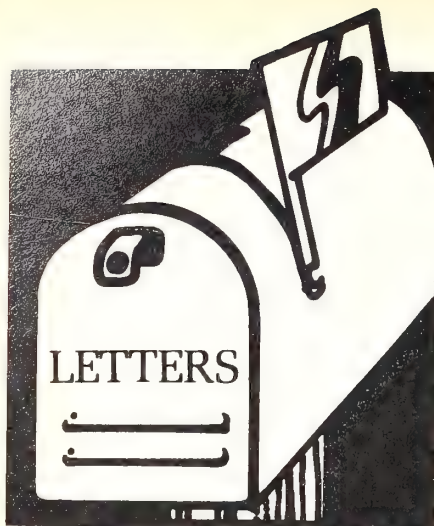
Not wishing to admit my ignorance on non-ophthalmological subjects, I began to "read up" on sports medicine, and found out how things had changed since I had played — and since medical school.

I and my teammates made it to our 25th college reunion in fairly good shape — continuing testimony to the sturdiness of the human body.

My involvement began again when my sons began showing up with a wide array of ailments and wanting to know how to care for them. Not wishing to admit my ignorance on non-ophthalmological subjects, I began to "read up" and found out how things had changed since I had played — and since medical school. I attended meetings and found out what a "stinger" was, and how to tape an ankle. Thanks to the proximity, acces-

who choose this avenue of community service (sounds like a plug for Rotary).

I urge all of you to do two things. First, read the articles in this issue of the **Journal**, and second, check to see that your area schools all have physicians as their team doctors. You may be surprised to find that many do not, and what an opportunity for you to further serve the health needs of our state; work with a great bunch of kids and dedicated coaches; and, last but not least — have fun while you are doing it. **OSMA**



Letters ... to the editor

The final epidemic

TO THE EDITOR:

"Thoughts on the Nuclear Age" (Ohio State Medical Journal, June, 1983) is a first class article on the problems involved and should be read by every physician everywhere. My heartfelt thanks go to Dr. Roy H. Thompson for writing this article in such a concise matter on solid scientific information and for considering a certain historical perspective in the format.

We physicians get too preoccupied with our daily routine and there exists the absolute danger we may fail to prevent the final epidemic. Victor Adler once said, "Medicine is health care for the individual, health care for the population at large is politics."

Sincerely,

Arnold J. Sattler, M.D.
Gallipolis, Ohio

Do you have a grievance to air, an opinion you'd like to share? Please send your "Letters to the Editor" and "Second Opinion" articles to: Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

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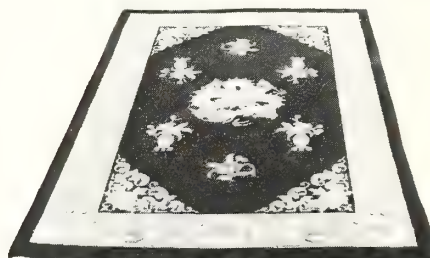
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Second Opinion

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

LASERS: Proceed with Caution

by R.V. Gracilla, M.D.

Advertisements appear with increasing frequency in the local papers for laser surgery, exhorting the effectiveness of this new approach of surgical treatment in the extremities, especially the foot.

Meanwhile, at a recent annual meeting of the American Academy of Orthopedic Surgeons, a plea was made regarding the overenthusiastic use of the laser, due to serious permanent injury, particularly on the articular cartilage of joints.

Since the discovery of the laser in

reports state that the CO₂ laser is still contraindicated for fine structure surgery in orthopedics.

The largest area of concern lies with the basic mechanism of the laser. In essence, it converts energy in the tissues so intensely that rapid evaporation, or simple "vaporization" of tissues occurs in a matter of split seconds. Some thermal damage by carbonization and other irreparable tissue damage is inevitable. The crater produced by the laser beam stimulates that of a "volcano crater" by electron

Researchers in the field strongly recommend special training prior to human applications. The surgeon, therefore, bears the responsibility of knowing how to use the laser, and the patient is entitled to be aware of the physician's training in this area.

1960, the CO₂ laser has been developed with regard to its applicability to medicine. Yet, the use of laser in medicine, specifically in surgery, is still in a stage of infancy. It is now well established in ophthalmology and certain microendoscopic surgery, but in the specialty fields, it is in a stage of definition.

In orthopedic surgery, the indications are limited — among these malignant tumors, coagulopathies and certain synovectomies. Reports in the orthopedic literature are still sketchy, however, and at this time, most

microscopy. Precision depth during delivery is mandatory. There is no finite margin for error. The consequence is, therefore, ominous.

Researchers in the field strongly recommend special training prior to human applications. The surgeon, therefore, bears the responsibility of knowing how to use this advanced therapeutic tool and the patient is entitled to be aware of the physician's training. The risk of exposing patients to this procedure without training and experiences may raise a major question of informed consent.

History reminds us of the time when
continued on page 649

*"I can do things that I
couldn't do for 3 yrs. including
joining the human race again."*



Quotes from an unsolicited
letter received by Pfizer from an
angina patient.
While this patient's experience
is representative of many
unsolicited comments received,
not all patients will respond to
Procordia nor will they all
respond to the same degree.

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*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



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(NIFEDIPINE) Capsules 10 mg

*Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA brief summary on adjoining page.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Lasers: Proceed with Caution

continued

x-ray treatment of the thymus, skin lesions such as warts, etc. developed such blatant complications that they are still being painfully paid for in terms of cancer, amputations and litigious awards, many years after the fact.

Anything new is historically viewed with skepticism. However, as physicians, we should look into these therapies with an open mind and a healthy respect, not only for their potential harm but their potential good as well. New therapy is only acceptable if it offers a technical advantage over conventional existing treatments. Yet, we should not become inflexible, lest we become stagnant. Prudence requires that time be the judge. We should allow unexpected errors to work themselves out, and build a meaningful, scientific data research base before we jump onto the laser band wagon.

My concern rests upon those in the local community who may be misinformed about the hazards of laser surgery. Otherwise, we are guilty of a conspiracy of silence.

My problem is the *modus operandi*. How do we accomplish this without our intentions being misconstrued? Will we be left behind a technological avalanche, or will we be accused of being jealous on purely economic grounds? I submit that this is indeed an emotionally packed and sensitive subject, not without repercussions regardless of the course of action we take.

Nevertheless, it behooves us to stand up and be counted — to make the public aware, by whatever means wisely available, of this double-edged sword. The abuse of this modality now may inhibit its vast therapeutic potential in the future. **OSMA**

R.V. Gracilla, M.D., an OSMA member, practices orthopedic surgery in Warren, Ohio.

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Colleagues In The News



The Ohio Hospital Association recently presented its Distinguished Service award to **JOHN H. ACKERMAN, M.D.**, Columbus, in recognition of his leadership and support as Director of the Ohio Department of Health from 1975 to 1983. Dr. Ackerman is the only recipient who has not been directly involved in the hospital industry.

FRANK BALDAUF, M.D., Lima, has accepted the position as Medical Director of Lost Creek Care Center and is responsible for the overall coordination of medical care at the facility. In his position, he will also be serving as liaison between the administrator, attending physicians and medical staff.

HENRY G. CRAMBLETT, M.D., Columbus, professor in the College of Medicine at Ohio State University, has been re-elected to a two-year term on the executive board of the National Board of Medical Examiners.

J. WARD DOERING, M.D., Logan, was honored with a plaque, honoring his 44 years of service to the Hocking County community. Dr. Doering retired from practice this past December.

CONSTANCE DONLEY, M.D., Ashland, was one of two new members named to the Samaritan Hospital board of trustees and officers for 1983-84. Dr. Donley is an internal medicine specialist in private practice.

W.P. DRAKE, M.D., Richwood, was recently inducted into the prestigious "Ohio Senior Citizens Hall of Fame," in ceremonies taking place at the Martin Janis Senior Center on the Ohio State Fairgrounds.

MOSES HARTMAN, M.D., Cleveland, received the "Golden Stethoscope Award" for 50 years of service on the staff of the Mt. Sinai Medical Center.

THOMAS A. HELMRATH, M.D., the Ohio Board of Regents' vice chancellor for Health Affairs, has been selected Medical Director at Riverside Methodist Hospital. In the newly-created position of medical director of the hospital's 600-member medical and dental staff, Dr. Helmrath will serve as a link between the physicians and Riverside's administration and board of trustees.

ROBERT HINES, M.D., Alliance, was named "1983 Man of the Year" at a joint meeting of the Kiwanis, Rotary and Lions Club, held recently. Dr. Hines was presented with a plaque.

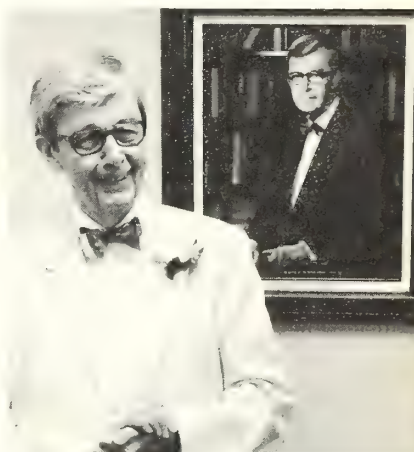
Riverside Methodist Hospital's new Pathology conference room was dedicated recently in honor of Dr. **RALPH JOHANSMANN**, emeritus medical staff member who retired as Riverside's Director of Pathology in 1975. Dr. Johansmann, an OSMA member, is currently in private practice in Columbus.

The Mt. Sinai Medical Center's Julius E. Goodman award was recently presented to **LAWRENCE MARTIN, M.D.**, of Chagrin Falls. Dr. Martin was cited for contributions to the advancement of patient care, medical education and clinical research.

continued on page 653



Thomas A. Helmrath, M.D., Cleveland . . . from vice-chancellor to medical director.



Ralph Johansmann, M.D., Columbus . . . Pathology director remembered.



Joseph A. Solomayer, M.D., Columbus . . . President of Tri-State Occupational Medical Association.

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Colleagues in the News

continued

WASSEF MIKHAIL, M.D., of Sylvania, demonstrated posterior stabilized knee surgery in England and Spain early this summer — the first time it has been performed on the European continent. Dr. Mikhail is director of education in orthopedics at St. Vincent Hospital and Medical Center.

CHARLES D. PARSONS, M.D., of Springfield captured low gross honors in the "Dr. Carm Shames Memorial Golf Tournament" sponsored by the Ohio State Medical Golfers and held this past June at Moundbuilders Country Club, Newark. Dr. Parsons shot a three-over par 74.

CHUNGKIL L. KANG, M.D., of Ashland was the winner in the overall low net competition. Dr. Kang's gross score of 93 combined with a 24-stroke handicap gave him the winning score of net 69.

The 1983 competition honored the late C.J. "Carm" Shames, M.D., of Mansfield, who died suddenly in January 1983. Dr. Shames had served as president of the Ohio State Medical Golfers Association and chief architect of the annual tournament for many years.

WALTER A. REILING, JR., M.D., a surgeon in private practice in Dayton, Ohio, was elected to the Governing Council of the newly formed Hospital Medical Staff Section of the AMA.

Dr. Reiling, who has served as a Delegate from the Montgomery County Medical Society to the OSMA House of Delegates for the past five years, was chosen at an informal meeting at the OSMA Annual Meeting to be the candidate from Ohio for the Governing Council.

ANNE W. ROBINSON, M.D., of Louisville, was recently honored in a celebration marking her 80th birthday,

and 26 years at the Molly Stark Hospital in Louisville, Ohio. Dr. Robinson, the hospital's Associate Medical Director, and Director of its Alcohol Detoxification and Rehabilitation Program, was the first female doctor hired at Molly Stark. She joined the staff in 1957, and has served as the Medical Director of the Rehabilitation Program for the past five years.

The University of Toledo Alumni Association presented its service award to **ROBERT SHEON, M.D.** Dr. Sheon, a 1955 UT graduate, founded and is a member of the rheumatology department of Toledo Clinic, Inc.

JOSEPH A. SOLOMAYER, M.D., Cleveland, Associate Professor of Northeastern Ohio Universities College of Medicine, will assume the Presidency of the Tri-State Occupational Medical Association (Ohio-Pennsylvania-West Virginia) this October. Dr. Solomayer also will be Chairman of the AMA Congress on Occupational Health to be held in Cleveland in co-sponsorship with the Tri-State Occupational Medical Association.

WILLARD C. STONER, JR., M.D., Chagrin Falls, was recently named "Clinician of the Year" by the Academy of Medicine of Cleveland. Dr. Stoner, who practices internal medicine and hematology-oncology, was awarded with a plaque which stated the reasons for his designation: "... over many years, his concern for patients exemplifies the highest ideals and ethics of the medical profession and personal devotion to those he serves."

FREDERICK T. SUPPES, M.D., Mayfield Heights, has been named to the Ohio Public Health Council.

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Rebecca J. Doll**

"Amenities" improve as competition increases

Competition among physicians, especially in urban areas, has resulted in less time in the waiting room and more time with physicians, according to a recent survey conducted by the Bureau of Health Professions.

The report, "Health Care Utilization and Expenditure Patterns," indicates that the growing supply of physicians may lead physicians to improve their "amenities" toward patients as competition for patients continues to increase.

According to the survey, patients waited an average of two days less for appointments in 1979 (3.3 days) than in 1975 (5.6 days) and spent a "significant" 72 seconds less (from 21.5 minutes to 20.4 minutes) cooling their heels in the waiting

room.

Dr. John A. Drabek, supervisor of the research, says that "qualitative improvements in physician services come at a price," and that "taking quality into account, medical services may be a better buy in areas with higher physician-to-population ratios."

The report also found that increased service amenities did not apply to Medicaid patients. According to Dr. Drabek, Medicaid patients probably spend more time in waiting rooms and less time with the physician. He notes that "physicians with a high-amenity style of practice tend to avoid Medicaid patients because of the program's traditional low level of reimbursement."

FDA reviews priorities

The Food and Drug Administration (FDA) recently issued a report which discusses priorities for fiscal year 1985, as set by professionals and professional organizations.

The three FDA activities that professionals (physicians, pharmacists, dentists, veterinarians, allied health professionals) felt should receive increased resources in fiscal 1985 were premarket approval activities; research on biological effects; and inspection and product testing. The three FDA activities the professionals felt should receive decreased resources include reassessment of previously approved products; consumer, professional and industrial information exchange; and product labeling activities.

The FDA periodically invites professionals to submit their opinions as to possible changes in emphasis among FDA activities. This helps the FDA identify the professional's perception of how important various agency programs are to the public safety and health.

MISCELLANEA

As of June 20, 1983, a total of 1,641 cases (13 in Ohio) of acquired immunodeficiency syndrome (AIDS) has been reported to the Center for Disease Control. These cases were diagnosed in patients who had Kaposi's sarcoma (KS) or an opportunistic infection suggestive of an underlying cellular immunodeficiency. Of these patients, 644 (39%) died. Groups at highest risk of AIDS continue to be homosexual and bisexual men (71% of the cases), intravenous drug users (17%), persons born in Haiti and now living in the U.S. (5%), and patients with hemophilia (1%).

From 1966 to 1981 the estimated number of consultations for condyloma acuminata (genital and venereal warts) with office-based, private physicians in the U.S. increased 459%, according to the Center for Disease Control. The number of consultations rose from 169,000 in 1966 to 946,000 in 1981. By comparison, the number of consultations with private physicians for genital herpes was

295,000 in 1981. Condyloma acuminata are Papillomavirus-induced soft, pink growths that appear singly or in clusters in moist areas around the genitalia and rectum and is one of the most common sexually transmitted diseases in the U.S. Morbidity and complications associated with it can be severe, and one study has shown a positive epidemiologic association between genital warts and cervical carcinoma.

Major drug firms are pushing a bill for longer patent usage. At issue is the six to seven years it takes the Food and Drug Administration to approve a new drug. The bill would give drugs 17 years protection after FDA approval as opposed to 17 years from the time the patent is applied for. Supporters say the added time will mean more new drugs developed that wouldn't be made otherwise because of marginal profits. Consumer groups and generic drug manufacturers oppose the bill.

Previewing the new hypertension drugs



American physicians who already feel overwhelmed by the number of available antihypertensive agents can expect even more, and perhaps better, therapeutic choices in the future — and also possibly greater confusion according to a report in *Medical World News*.

Safety and efficacy studies, clinical trials, and available drugs in Europe tend to migrate to the U.S., and reports presented at the first European meeting on hypertension suggest new indications, dosages, and delivery systems for FDA-approved drugs. In addition, they suggest new NDAs will be filed here for agents not yet marketed in the U.S. Available U.S. drugs are:

Captopril (Capoten, Squibb): Five studies showed safety and efficacy in b.i.d. compared with t.i.d. doses; presented at a satellite symposium sponsored by Squibb.

Verapamil (Calan, Searle; Isoptin, Knoll): One study showed efficacy of b.i.d. doses for mild-to-moderate hypertension; another reported improved fetal outcome among mothers treated with verapamil.

Nifedipine (Procardia, Pfizer): Sublingual delivery reported effective; b.i.d. dosage reported safe and effective in three studies.

Clonidine (Catapres, Boehringer Ingelheim): Two studies showed a transdermal delivery system as effective as oral doses.

Metoprolol (Lopressor, Geigy): Effective as a once-a-day agent. Drugs not yet available in U.S.

Beta-blockers

Prizidilol hydrochloride: Eight studies showed efficacy of this once-a-day vasodilator and nonselective beta-blocker.

Labetalol: Shown effective at three different centers. Four studies showed labetalol combined in a tablet with the diuretic chlorthalidone (RG136, Glaxo) controlled hypertension better than either drug alone.

Betaxolol: Four positive studies of this selective beta₁-blocker, plus one report on its usefulness as a once-a-day agent.

Other beta-blockers (one or two

studies of each): Oxprenolol plus chlorthalidone effective in continuous 24-hour blood pressure control; bucindolol, an alpha- and beta-blocking agent with additional direct vasodilating action; indenolol, a beta-blocker that decreases platelet aggregation; acebutolol (Sectral, RBS Pharma), a cardio-selective beta-blocker with intrinsic sympathomimetic activity (ISA); BM 14190, a vasodilator and beta-blocker without ISA; and KOE 4302, shown to have high beta₁ selectivity.

Angiotensin converting enzyme inhibitors

Enalapril (Merck): Studies of 3,000 patients showed effectiveness in essential and renovascular hypertension, improvement in symptoms of congestive heart failure, and low incidence of side effects; presented at a day-long Merck satellite symposium.

SQ26,900 (Squibb): An analog of captopril, shown effective as a once-a-day agent. Representatives from Squibb said they have also applied for an NDA for Capozide, a combination of captopril and a thiazide diuretic.

MK-421: Administration resulting in lower blood pressures in one study.

Vasodilators

Pinacidil: Demonstrated efficacy as a precapillary vasodilator.

Cadralazine: Long-acting vasodilator shown effective by itself in three studies; effective in combination with chlorthalidone in one study; effective in combination with metoprolol in two studies.

Felodipine: Five studies showed effectiveness in selective action on smooth muscle.

Nicardipine: A peripheral vasodilator.

Endralazine: A direct-acting peripheral vasodilator.

Diuretics:

Torsemide, a new loop diuretic; muzolimine, a sulfonamide-free diuretic; and xipimide.

Other antihypertensive agents:

Ketanserin: A selective serotonin (5-hydroxytryptamine receptor) antagonist. Thirty separate studies reported effectiveness in mild,

moderate, and severe hypertension; in reducing vasospasm; in elimination of Raynaud's syndrome; and in treatment of preeclampsia and eclampsia.

Indoramine hydrochloride: A selective alpha₁-blocker; RX781094, a selective alpha₂-blocker; CP804-S, a phenylethylamine derivative with probable selective alpha₁-blocking activity; and guanfacine, a central-acting guanidine (Sandoz).

Seminars to sharpen practice management skills

Physicians interested in sharpening their practice management skills and those of their staff are invited to attend one or all of the three practice management programs which are being jointly sponsored this month by the Ohio State Medical Association and the American Medical Association.

"Team Building — A Better Way to Supervise" has been designed to sharpen the skills of your medical office manager and will include discussions on how to recruit candidates for your practice, develop job descriptions, and organize an effective staff meeting.

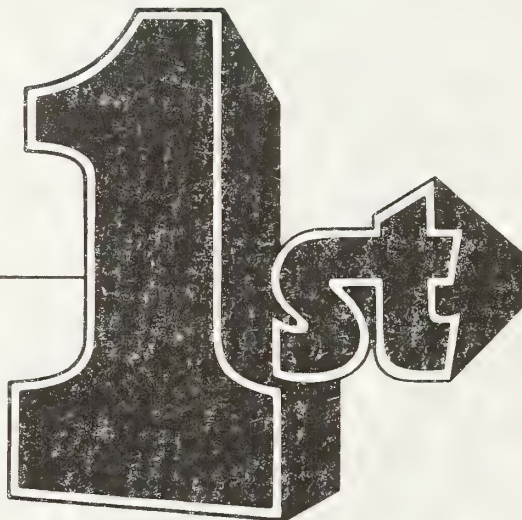
"Starting Your Practice" is geared to give those physicians, planning to enter private practice, the tools necessary to make the practice a success. Topics will include: selecting a location, motivating staff and establishing an accounting system.

At the other end of the spectrum, "Gearing up for Retirement" will answer questions for those physicians who are planning their retirement.

The courses will be held September 14, 15, and 16 at the Marriott Inn North, Columbus, Ohio. For further information, contact: The Department of Education, Specialty Society and Meeting Management, The Ohio State Medical Association, 600 S. High Street, Columbus, Ohio 43215.

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**A unique controlled-release
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In hypertension, angina,
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Smooth 24-hour control

Unsurpassed simplicity
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Single daily dosage for
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INDERAL[®] LA
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80 mg



120 mg



160 mg

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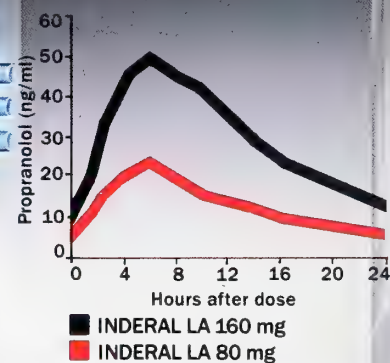
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MEAN PLASMA LEVELS
ATTAINED WITH INDERAL LA
OVER 24 HOURS



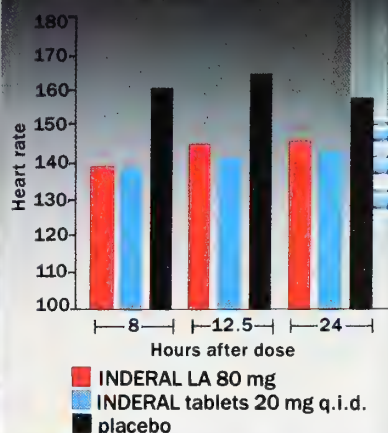
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Sustained plasma levels

In pharmacokinetic studies, blood levels with once-daily INDERAL LA were found to be adequate to maintain sustained clinical effect throughout 24 hours. The unique controlled-release formulation of INDERAL LA minimizes differences between peak and trough plasma concentrations.

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EFFECT ON POST-EXERCISE HEART RATE OVER 24 HOURS*



AND 24-HOUR BETA BLOCKADE

Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose—with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

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*INDERAL LA vs. tablets: N.S. at all hours measured.

*INDERAL LA vs. placebo: $p < .05$ at all hours measured.

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THE ONE
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FOR INITIAL
THERAPY IN HYPERTENSION

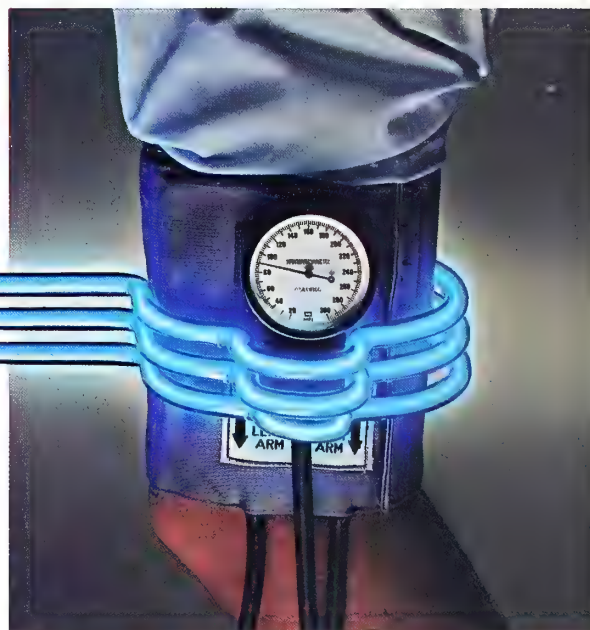
Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

**Unsurpassed convenience
and simplicity**

Enhanced patient compliance





THE
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TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of INDERAL

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

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(PROPRANOLOL HCl) LONG
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80 mg

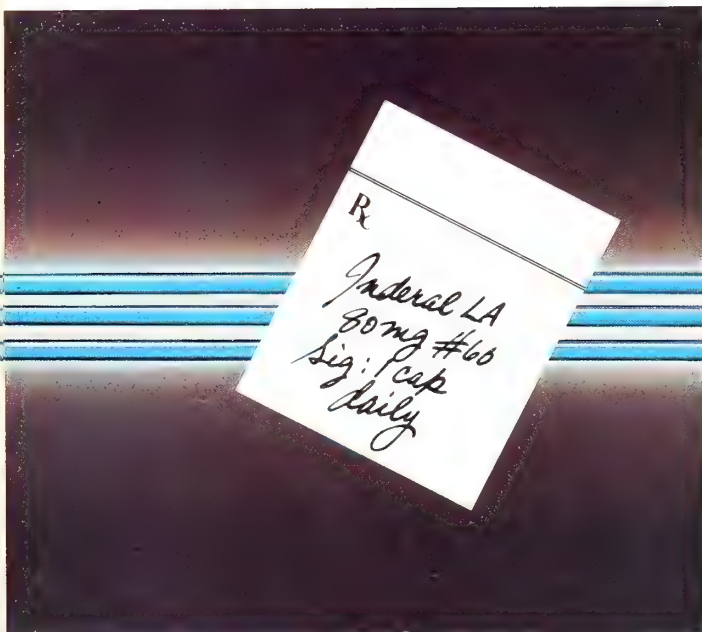


120 mg



160 mg

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once daily

Smooth 24-hour control

Unsurpassed simplicity and
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Enhanced patient compliance

Three strengths for prescribing
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For arrhythmias, use
conventional INDERAL® tablets

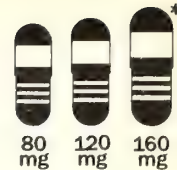
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Please see last page for Brief Summary of Prescribing Information.

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ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® LA brand of propranolol hydrochloride

(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In doses greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSEAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories. 8511/783

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Report from the AMA's Annual Business Meeting

By Oscar Clarke, M.D. and S. Baird Pfahl, M.D.

EDITOR'S NOTE:

This report covers some of the important issues voted on by the Ohio Delegation at the 1983 annual business meeting of the American Medical Association in Chicago, Illinois, June 19-23, 1983.

There were 53 reports and 109 resolutions considered by the House of Delegates. Eight of the resolutions were introduced by the Ohio Delegation and one was introduced by Oscar W. Clarke, M.D., Chairman of the Ohio Delegation to the AMA.

Proposed Regulations for Non-Physicians

The first Ohio resolution, Proposed Regulations for Non-Physicians, was combined with two other resolutions. The AMA House of Delegates adopted the following amended substitute resolution:

"RESOLVED, That the American Medical Association adopt the following definition of 'physician' including doctors of osteopathy as follows:

'A physician is a person who has been admitted to a medical school or a school of osteopathic medicine which school is approved by his or her state licensing board and has successfully completed the prescribed course of studies in medicine or osteopathic medicine and has acquired the requisite qualifications to be legally licensed to practice medicine or osteopathic medicine'; and be it further

RESOLVED, That the AMA initiate and support legislation in the 98th Congress to amend appropriate sections of the Social Security Act to limit the use of the term 'physician' to describe only doctors of medicine or osteopathic medicine, not only in the act itself, but also in regulations promulgated thereunder, without changing the current level of covered

services provided by Medicare."

The Ohio Delegation supported adoption.

Therapeutic Substitution of Drug Products

The second Ohio resolution, Therapeutic Substitution of Drug Products, was adopted by the AMA House of Delegates as follows:

"RESOLVED, That the American Medical Association vigorously oppose any concept of therapeutic substitution of drugs by pharmacists."

The Ohio Delegation unanimously supported adoption.

Informational Programs by Pharmaceutical Companies and Medical Appliance Manufacturers

The AMA House of Delegates adopted Board of Trustees Report KK in lieu of the Ohio resolution and a resolution for the Medical Student Section on the same subject. Board of Trustees Report KK concludes and recommends the following:

"Prescription drug advertising, whether to the health professional or to the public, that is false or misleading or does not give adequate information on beneficial as well as adverse effects is potentially dangerous and should be opposed. Such problems will be particularly

troublesome in advertisements for drugs used for treatment (as opposed to prevention) purposes and in advertisements of brief duration, except those limited to the price of drugs, such as radio and TV commercials.

Despite its generally negative attitude on this subject, the Board believes that a thorough airing of views and the evaluation of all pertinent facts should take place before recommending specific AMA policy. To this end, the Association has transmitted the following comments to the Commissioner of the Food and Drug Administration:

'We recognize the importance of gathering as reliable information as possible on the attitudes of physicians, the public and pharmaceutical manufacturers toward such advertising and the effects on patients and physicians of public advertising of prescription drugs. We support the efforts currently underway in the FDA to gather such information prior to arriving at a decision. We also support the moratorium on such advertising that you have recommended to pharmaceutical manufacturers and to advertising agencies and the media.'

The Board of Trustees commends the ethical pharmaceutical industry for its restraint and measured response to the great and increasing public demand for more information on prescription drugs. At the same time, the Board has major concerns about advertising directed to the public for drugs that are available exclusively on a prescription basis. The Board recommends that the Food and Drug Administration act promptly to review this issue and to provide recommendations. The Board further recommends that the advertising of prescription drugs to the public be held in abeyance pending the FDA's review."

The Ohio Delegation unanimously supported adoption.

Drug Availability

The fourth Ohio resolution, Drug Availability, was adopted by the AMA House of Delegates. The resolution is listed below:

"RESOLVED, That the American Medical Association urge the Food and Drug Administration (FDA) to complete its evaluation of those drugs which 'lack adequate evidence of effectiveness' and invite practicing physicians to provide it with information and comments on their clinical experiences with those drugs; and be it further

RESOLVED, That the AMA urge the Department of Health and Human Services to consider all drugs approved by the FDA for marketing eligible for reimbursement."

The Ohio Delegation unanimously supported adoption.

Preferred Provider Organizations

The fifth Ohio resolution, Preferred Provider Organizations, was referred to the AMA Board of Trustees. The Board of Trustees is aware of the timeliness of this issue and will be presenting a report to the AMA House of Delegates at the 1983 AMA Interim Meeting.

The Ohio Delegation unanimously supported referral.

Problems of the Senior Citizens

The sixth Ohio resolution, Problems of the Senior Citizens, was referred to the Board of Trustees.

The Ohio Delegation supported referral.

Boxing as a Health Hazard

The seventh Ohio resolution, Boxing as a Health Hazard, was amended and adopted by the AMA House of Delegates as follows:

"RESOLVED, That the American Medical Association:

1. Publicize the deleterious effects of boxing on the health of participants.
2. Encourage the elimination of boxing from amateur scholastic, intercollegiate and governmental athletic programs as detrimental to the health of participants.
3. Develop model legislation seeking to curtail the utilization of boxing as a public spectacle to the extent feasible."

The Ohio Delegation unanimously supported adoption.

Proposed Revisions of JCAH Standards

The eighth resolution submitted by the Ohio Delegation, Proposed Revisions of JCAH Standards, was combined with twenty-one other resolutions. The following substitute resolution was adopted by the AMA House of Delegates:

"RESOLVED, That the House of Delegates commend the American Medical Association Board of Trustees for its responsible consideration of the difficult issues confronting the Joint Commission on Accreditation of Hospitals, and affirm the following principles as the basis for any revision of the Medical Staff Section of the *Accreditation Manual for Hospitals*:

1. Continue the use of the term "Medical Staff" in the title of the chapter and throughout the Manual;
2. Delete any specific references to limited licensed practitioners now contained in the Medical Staff chapter of the 1983 *Accreditation Manual for Hospitals*. This does not preclude such practitioners from having hospital privileges consonant with their training, experience and current competence if approved by the normal credentialing process.
3. Provide consideration of qualified

- limited licensed practitioners in accordance with state law and when approved by the executive committee of the medical staff and by the governing board and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners;
 4. Provide that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; and
 5. Assure that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine and Doctors of Osteopathy) to ensure the continued high quality of care, credentialing of physicians and other licensed practitioners and effective quality assurance programs; and be it further
- RESOLVED, That the AMA Board of Trustees direct its Commissioners to the Joint Commission on Accreditation of Hospitals to request a delay in final approval to any revisions to the Medical Staff chapter of the *Accreditation Manual for Hospitals* until after soliciting and considering comments from the AMA House of Delegates, medical societies, hospital medical staffs, hospitals, and medical specialty organizations."**
- The Ohio Delegation unanimously supported adoption.**

Corporal Punishment in Schools

The Ohio resolution submitted by Oscar W. Clarke, M.D., Chairman of the Ohio Delegation, Corporal Punishment in Schools, was referred to the AMA Board of Trustees.

"The resolution asked the AMA to support abolition of corporal punishment in schools, inform school

boards of its action, and work with the American Academy of Pediatrics to implement this policy.

The AMA House of Delegates recognized the potential dangers of corporal punishment in schools, but has no information on the extent of this problem. The House of Delegates believes this subject should be evaluated by the Board of Trustees before any public statement is contemplated."

The Ohio Delegation unanimously supported referral.

Resident Member of the AMA Board of Trustees

The AMA House of Delegates adopted a Board of Trustees report that provides for a resident physician member who would be elected by the House for a term of two years, with a maximum of three terms.

The Ohio Delegation unanimously supported adoption.

Medical Student Non-Voting Member of the Board of Trustees

The AMA House of Delegates adopted a Board of Trustees report creating a non-voting medical student position on the AMA Board of Trustees. This position would be filled on an annual basis by appointment by the Board from two or more nominations presented by the AMA Medical Student Section Governing Council. The individual appointed would be eligible for re-appointment as long as he or she remains a medical student member of AMA.

The Ohio Delegation unanimously supported adoption.

Interprofessional Relations with Nurses

The AMA House of Delegates adopted the following Judicial Council report:

"The primary bond between medical practice and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to explain those orders to the nurse involved. Whenever a nurse recognizes

or suspects error or discrepancy in a physician's orders, the nurse has an obligation to call this to the attention of the physician. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice. In emergencies when prompt action is necessary and the physician is not immediately available, in the performance of reasonable care a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient. Such occurrences should not be considered to be a breakdown in professional relations."

The Ohio Delegation unanimously supported adoption.

Study of Cost Shifting

The AMA House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association Board of Trustees study the effects of cost shifting on patients, physicians, third party payors and hospitals, and report its findings to the House of Delegates."

The Ohio Delegation unanimously supported adoption.

Medicare Coverage of "Skilled Nursing Care"

The AMA House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association take appropriate action to encourage the Health Care Financing Administration to (1) clarify the Medicare definitions of "skilled nursing care" and "custodial care," (2) identify and implement appropriate measures to assure greater consistency in the administrative interpretation of rules governing coverage of nursing home care, and (3) better explain to beneficiaries the exclusion for custodial care services."

The Ohio Delegation unanimously supported adoption.

Reimbursement for CT Scans and Other Procedures

The AMA House of Delegates adopted a Council on Medical Service report that opposes denial of payment to physicians based solely on specialty, opposes reimbursement policies which discourage provision of

care in the most cost-effective setting, and opposes denial of payment by third parties solely on the basis that the services billed were provided on equipment not approved by placement review.

The Ohio Delegation unanimously supported adoption.

Local Initiatives to Help the Needy

The AMA House of Delegates filed a Council on Medical Service Report that is an informational report on medical society sponsored programs to provide free or reduced-fee care for the needy.

The Ohio Delegation unanimously supported this action.

Consumer Choice Principles

The AMA House of Delegates adopted a Board of Trustees report regarding Consumer Choice Principles. The revised principles include issues such as employment-based health insurance, adequate benefits, multiple choice of plans, equal contributions, limitation on tax deductibility of excessive health insurance premium, rebate to employees, and quality of care.

The Ohio Delegation unanimously supported adoption.

Opposition to Regulations Promulgated to Implement the 1982 P.L. 97-248 (TEFRA)

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association continue to give a high priority to prompt withdrawal of regulations to implement Section 108 of TEFRA, and until such withdrawal continue its opposition to inappropriate elements of these regulations, including arbitrary definitions of the practice of medicine and limits on medical consultations, through appropriate actions in the legislative, executive and judicial arenas."

The Ohio Delegation unanimously supported adoption.

Pension and Profit Sharing Program

The AMA House of Delegates referred the following resolution regarding Pension and Profit Sharing

Program to the AMA Board of Trustees:

"RESOLVED, That the American Medical Association cooperate with small business and the other professional groups in seeking to prevent further erosion of the benefits of retirement programs (certain pension and profit sharing plans) and develop legislation to restore and enhance the provisions of these retirement benefit programs for small business people and professionals." **The Ohio Delegation unanimously supported referral.**

Certificate of Need

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association continue to seek repeal of the National Health Planning and Resources Development Act of 1974, P.L. 93-641, as amended, and, until the Act is repealed, to seek a legislative amendment to remove or delay those portions of the Act which impose penalties on states not in compliance with federal certificate of need criteria."

The Ohio Delegation unanimously supported adoption.

Anonymity for Resident Inquiries to Residency Review Committees

The AMA House of Delegates adopted a Council on Medical Education report that describes a procedure developed to guarantee the anonymity of a resident physician who initiates an inquiry by a residency review committee into the conduct of a residency program. **The Ohio Delegation unanimously supported adoption.**

Physician Exemption from Medical School Standards and Performance Evaluation Requirements

The AMA House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association recommend to medical licensing boards that those physicians who are foreign medical graduates currently duly licensed by any licensing jurisdiction in the United States should not be denied endorsement of their licenses, or

denied admission to re-examination when this is required by law, solely because they are unable to provide documentation of graduation from a school meeting 'equivalent standards and performance evaluation requirements' to those of programs accredited by the Liaison Committee on Medical Education. It is recommended that licensing boards, in reviewing applications for licensure endorsement, take into account a physician's ethical standards and his or her having practiced medicine of an acceptable quality."

The Ohio Delegation unanimously supported adoption.

Chelation Therapy

The AMA House of Delegates adopted the following two resolutions:

Resolution 57 (A-83)

"RESOLVED, That, based upon recommendations and reports from various prestigious organizations and publications such as the American Heart Association, the American College of Physicians, the 'Harvard Medical School Health Letter' and the 'Medical Letter,' the American Medical Association declare the chelation therapy of atherosclerosis be presently considered an experimental process without proven efficacy; and be it further

RESOLVED, That chelation therapy be researched by the AMA Council on Scientific Affairs, with a report on its proper uses submitted to the House of Delegates at the Interim Meeting."

Resolution 70 (A-83)

"RESOLVED, That the Council on Scientific Affairs or the appropriate council, committee or authority of the American Medical Association study the indications, efficacy, safety and potential benefits and risks of chelation therapy, including those diseases and conditions for which it is being advertised to the public (gangrene, senility, blindness, hypertension, heart pains, kidney stones, loss of memory and arthritis), and report its findings to the House of Delegates as soon as possible in a form permitting rapid transmission of this information to state associations and county societies." **The Ohio Delegation unanimously supported adoption.**

AMA DUES — 1984

The AMA House of Delegates adopted a Board of Trustees report containing the following dues schedule for 1984:

Regular Members	\$330
Physicians in Their Second Year of Practice	\$248
Physicians in Military Service	\$220
Physicians in Their First Year of Practice	\$165
Physicians in Residency Training	\$ 45
Medical Students	\$ 20

Note: The regular member annual dues increase for 1984 was reduced from \$25 per year to \$15 per year. **The Ohio Delegation supported adoption.**

Establishment of State Hospital Medical Staff Sections

The AMA House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association House of Delegates encourage every state medical association to establish a statewide hospital medical staff section; and be it further

RESOLVED, That the American Medical Association be requested to develop guidelines to assist the state associations in forming hospital medical staff sections." **The Ohio Delegation unanimously supported adoption.**

Freestanding Emergency Medical Care

The AMA House of Delegates adopted an amended Board of Trustees report that described a review of freestanding emergency medical care centers conducted by the Commission on Emergency Medical Services. It suggested initial criteria to aid in determining if a full range of emergency services is being offered. **The Ohio Delegation unanimously supported adoption.**

Payment for Physicians' Services

The AMA House of Delegates adopted an amended Council on Medical Service report that presents an analysis of payment mechanisms utilized by third party payors for reimbursement of physician's services. The report was amended to include

the following statement:

"Members of the House consider the matter of physician reimbursement by means of indemnity versus UCR with their constituents and other concerned parties over the next six months, communicate any additional views and comments to the Council, and come to the next Interim Meeting of this Association prepared to further express their views on the subject. Distribution should also be made to component and specialty medical societies requesting comments prior to the 1983 Interim Meeting."

Existing policy is stated below:

"Since 1965, it has been this Association's policy that the 'usual and customary or reasonable charge' concept should be the basis for establishing both government and private third party payments for physicians' services. The terms 'usual,' 'customary,' and 'reasonable' were defined by the Association in 1968, as follows:

Usual is defined as the 'usual' fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual fee);

Customary is defined as that range of usual fees charged by physicians of

similar training and experience for the same service within a given specific limited geographic or socioeconomic area;

Reasonable is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question."

The Ohio Delegation unanimously supported adoption.

Uniform Claim Forms

The AMA House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association assume a leading, active and aggressive role in the development and implementation of a single, national uniform claim form designed to meet the needs of the medical professional, government and third party payers; and be it further

RESOLVED, That the AMA assume a leading, active and aggressive role in the design of a uniform data set and format for the submission of paperless claims to both government and private third party payers."

The Ohio Delegation unanimously supported adoption.

Nationwide Legal Drinking Age of 21 Years

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association reaffirm its existing policy to encourage each state medical society to seek and support legislation to raise the minimum legal drinking age to 21; and be it further

RESOLVED, That the AMA urge all physicians to commit themselves to taking every available opportunity to educate their patients about the dangers of alcohol abuse in general and operating a motor vehicle while under the influence of alcohol in particular."

The Ohio Delegation unanimously supported adoption.

Oscar Clarke, M.D., Gallipolis, is Chairman of the Ohio Delegation to the American Medical Association. S. Baird Pfahl, M.D., Sandusky, is President of the OSMA

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|--|---|---|
| 1. Guidelines for Do-Not Resuscitate Orders | 8. Genetic Counseling; Artificial Insemination by Donor; and In Vitro Fertilization | 15. Reimbursement for CT Scans and Other Procedures |
| 2. Protocol for Emergency Medical Services Personnel — Status Report | 9. Sports Medicine | 16. Pharmaceutical Dissolution of Gallstones |
| 3. The Insanity Defense in Criminal Trials and Limitation of Psychiatric Testimony | 10. Implications of Trends in Public and Physician Attitudes | 17. Methaqualone: Abuse Limits Its Usefulness |
| 4. The Diminishing Family and Its Impact on Health | 11. Availability of First-Year Residency Positions and Opposition to Deficit Enrollment | 18. Choking: The Heimlich Maneuver (Abdominal Thrust) |
| 5. Health Policy Agenda for the American People — Progress Report | 12. Cost and Financing of Medical Education | 19. Update on Venereal Disease |
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| 7. Competition in Medicine: An Update | 14. Discontinuance of Federal Funding for Ambulatory Care Centers | 21. Current Issues in Pediatric Immunization |
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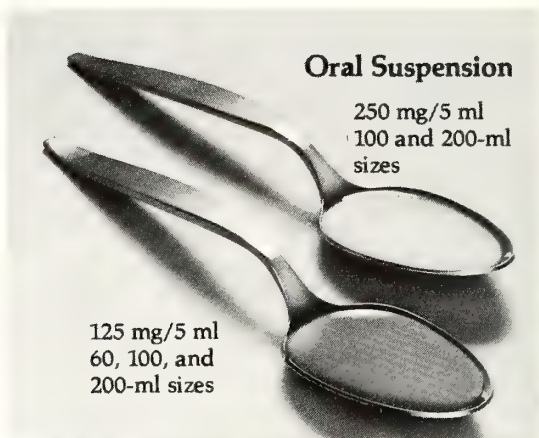
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**On
Record**

LAYING A NEW FOUNDATION

By Karen S. Edwards

Editor's Note: *Although the Ohio Medical Education and Research Foundation (OMERF) was founded by the Ohio State Medical Association six years ago, new interest was recently breathed into the program by Council action last year. Why the awakened interest? The Journal went to OMERF Board Chairman Oscar Clarke, M.D., Gallipolis, for the answers.*

THE OHIO STATE MEDICAL JOURNAL: Dr. Clarke, last year, OSMA's Council gave the authority to recruit members for an OMERF Board. Can you tell us what developments led to this action?
OSCAR CLARKE, M.D.: Both Frank Papay, who was President of the OSMA's Student Section during 1982, and the late Perry Ayres, M.D., who had been Chairman of the OSMA's Physician Effectiveness Program for the past six years, had expressed concerns to the OSMA about

JOURNAL: Could you elaborate a bit more on these concerns? For example, why are medical students experiencing such difficulty financing their education?

CLARKE: The cost of obtaining a medical degree has skyrocketed in recent years, and the figure continues to escalate. The medical student section conducted a survey in this area last year, and learned that the cost of a medical education at Ohio's medical schools increased 11-35 percent, from 1981 to 1982. A similar percentage

Because of the high costs of a medical education, we have seen many gifted students turn away from medical/research and primary care areas. They opted for a more lucrative subspecialty simply to manage their debt, incurred upon graduation. That is tragic.

problems that were developing in their respective areas.

Frank depicted the problems medical students were having paying for their education, and Perry had wondered what, if anything, could be done for those impaired physicians who had sought help for their illness, been rehabilitated, and were ready to resume practice, but lacked the economic means to do so. In an attempt to address these financial concerns, the Council decided to reactivate the Foundation it had established in 1977.

increase took place in 1983. Currently, 85 percent of Ohio's medical students are receiving financial aid. The problem is that debts accrue so quickly. Approximately 18 percent of those students borrowing have already accrued debts of over \$40,000.

JOURNAL: How does OMERF propose to help out?

CLARKE: One of the Foundation's goals is to make low-interest loans available to medical students.

JOURNAL: But what about Federal aid sources and other alternative loan

Ohio State Medical Journal

Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. The *Journal* will assume \$10 of this expense and the author will be billed by The *Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise re-statement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

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Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

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programs? Aren't there other avenues of financing open to the student?

CLARKE: Not really. The number of aid sources available to students — especially at the Federal level — have decreased or, at best, remained constant in recent years. And the alternative programs, such as HEAL (Health Education Assistance Loans) are available only at very high interest rates.

JOURNAL: Why should OMERF be so concerned with the escalating costs of a medical education?

CLARKE: Because, if it continues, it could have a dramatic impact on some of the facets of health care.

JOURNAL: Could you explain that further?

CLARKE: Yes, we have already seen many gifted students turn away from medical research and primary care areas. They opted for a more lucrative subspecialty simply to manage their debt, incurred upon graduation. That is tragic.

will be for those students from modest financial backgrounds. We're in danger of closing the door on some very qualified and talented people. That's why OMERF wants to make low-interest loans available to medical students. Everyone, regardless of their financial resources, should have an equal opportunity to study medicine, if that's what he or she wants to do.

JOURNAL: Do you see OMERF in competition with the American Medical Association's Foundation, AMA-ERF?

CLARKE: No, I don't. AMA-ERF has had a very viable program, but because it's national in scope, it operates differently. Many state medical associations have their own foundations, and have coexisted with AMA-ERF very well. There's no reason why OMERF can't do the same.

JOURNAL: What are the specific advantages in contributing to OMERF?

CLARKE: With regard to medical

One of the hurdles that OMERF must face is convincing prospective donors that physicians need money. The truth is there are physicians who, because of an illness, have lost their means of earning a living and are starting their medical practice, again, from the ground up — without having the resources, or credit, to do so.

We also have to consider how those students with significant debts are going to recoup the money to pay back their loans — and that is most likely going to be through their practices. That's going to mean higher charges, and with the cost of health care already peaking at all-time highs, it's difficult to imagine what's going to happen to those figures in the future.

Finally, we need to realize that the more it costs to educate a medical student, the fewer the opportunities

education assistance, the contributor knows that the money will be given specifically to an Ohio medical student. Contrary to AMA-ERF, OMERF should be able to provide more immediate assistance. Checks which come from the AMA-ERF are distributed once a year, and are sent to the dean of the medical school to be spent at his or her discretion. With OMERF, the student in need can obtain help much more directly, and much more quickly.

JOURNAL: Let's turn to the impaired physician for a moment — the one who is rehabilitated and wishes to continue practice. It is difficult for most people to believe that these physicians are really destitute. . . .

CLARKE: One of the hurdles that OMERF must face is convincing prospective donors that physicians need money. The truth is there are physicians who, because of their illness, have lost their means of earning a living and are coming back into medical practice from the ground up, without having the resources — or often the credit — to do so.

JOURNAL: But aren't these incidents rare?

CLARKE: No. You'd be surprised. Our Physicians Effectiveness Program has identified three such cases just in the past year. Several states, including Kansas and Michigan, already have similar funding programs set up to handle such situations in their states, so the situation is not unusual.

JOURNAL: Then, the money raised by OMERF will be used to grant low interest loans to medical students, and help rehabilitated physicians back into practice. What other projects might OMERF support?

CLARKE: Research projects — and other health-related activities, such as a teenage alcoholic treatment center, for example. Support for programs of this nature would be reviewed individually.

JOURNAL: How much money are you hoping to raise?

CLARKE: We'd like to raise \$350,000 over the next three years, but, then again, the sky's the limit.

JOURNAL: By what means do you intend to raise the money?

CLARKE: We will employ all appropriate fund-raising techniques to meet our goal. This will include both individual and corporate solicitation, as well as investigating other foundation support.

JOURNAL: Didn't the OSMA's House of Delegates recently approve an action that will allow for OSMA members to donate to OMERF?

CLARKE: Yes, that action was approved last May. Our members will see OMERF on their annual dues bill

for a \$10 donation.

JOURNAL: Is the donation tax deductible?

CLARKE: Yes. We also plan to let our members know how they can make generous gifts of property, securities and other tangible assets. Many physicians want to make a gift, but do not understand the best way to donate for their particular situation. We will be able to show a prospective donor how everyone (i.e. OMERF donor and family) can benefit from the aforementioned contributions.

JOURNAL: When will the foundation be able to actually start operations?

CLARKE: When we have raised at least \$75,000. We hope that by the fall of 1984 we can start making medical education and impaired physician loans. If 75% of our members respond positively to their dues statement, we can be in business before that time.

JOURNAL: Who will make the decisions as to who receives loans and who does not?

CLARKE: That will be the responsibility of the OMERF board. There will be a maximum of 12 members on the board — and it will be a mixture of physicians, auxiliary members, corporate leaders and others in the health care field.

JOURNAL: Is there anything about OMERF you wish to add in closing?

CLARKE: The Director of OMERF is Mr. Lou Saslaw. Anyone who has questions or is interested in more information on the Foundation should contact him at the Ohio State Medical Association, 600 S. High St., Columbus, Ohio 43215.

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.

HEAD INJURY PERSPECTIVES, 1983

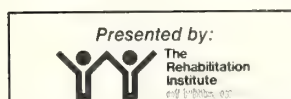
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Sports medicine

Making the Team

By Robert Clinger and Karen S. Edwards

Six new names were added to the roster as team physicians from high schools around the state became recipients of the 1983 "Outstanding Team Physician Award."

The team is not an easy one to make. It takes at least 20 years of service as a team physician for one of Ohio's high schools, and a "good word" from both colleagues and school officials with whom the physician works.

But each year, the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association, and the Ohio High School Athletic Association manages to find qualified

physicians who are eligible to receive the group's "Ohio Outstanding Team Physician" Award.

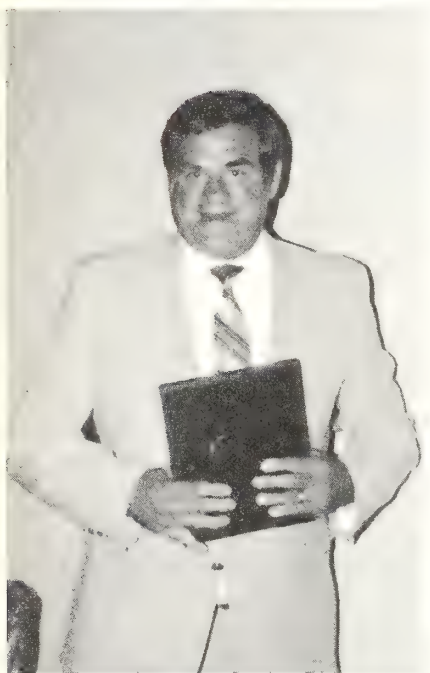
This year's awards were presented at the end of July in Canton, Ohio. The winners are profiled below. The team they've joined may not be an easy one to make, but, it seems to become bigger, brighter, and better than ever with each passing year. Congratulations to all of this year's award winners!

TONY ADAMLE, M.D.

Kent, Ohio

Tony Adamle, M.D., has been a team physician for Kent's Roosevelt High School for 25 years, and in addition has served as consulting team physician for both the Browns and San Francisco 49'ers during pre-season training camps at Kent State. In 1968, he served as team physician for the North-South High School All-Star Game, and in 1972, was honored by the Northeastern Ohio Athletic Directors Association as "Outstanding Team Physician."

A graduate of Case Western Reserve University, Dr. Adamle practices family medicine in Kent, where he lives with his wife, Kathleen, and their six children.



Tony Adamle, M.D.



J. Richard Hurt, M.D.

J. RICHARD HURT, M.D.

West Jefferson, Ohio

J. Richard Hurt, M.D., has served as a team physician for West Jefferson High School since 1962. His community contributions have not ended on the playing field, however. Dr. Hurt also has served on the Jefferson Local School Board and the Madison County Board of Education — serving terms as president on each.

A graduate of the Ohio State University College of Medicine, Dr. Hurt moved to West Jefferson in 1962 where he established his family practice. He resides there with his wife, Sally, and their two children.

MICHAEL C. KOLCZUN, M.D.

Lorain, Ohio

Michael C. Kolczun, M.D., has served as a team physician for Admiral King High School for some 20 years, but his "career" as a team physician has spanned twice that length of time. A pioneer among Ohio physicians in promoting sports medicine training for coaches, he established a two-day program for Lorain County football coaches 30 years before such training was mandated by the Ohio State Board of Education. He also was responsible for establishing a football conditioning camp for Lorain High School.

Dr. Kolczun graduated from Louisiana State University Medical School before moving to Lorain, Ohio. He and his wife, Julie, have two sons — one of whom is in orthopedic practice with him.



Michael C. Kolczun, M.D.



A. Burton Payne, M.D.

A. BURTON PAYNE, M.D.
Ironton, Ohio

A. Burton Payne, M.D., has been team physician for Dawson-Bryant High School for over 20 years, and in that length of time he has won the respect and admiration of the community, graduates of Dawson-Bryant and the coaches of the Ohio Valley Athletic Association.

In addition, Dr. Payne has received the esteem of Ohio's medical community for an equal number of years of service to his colleagues in organized medicine. Currently President-elect of the OSMA, Dr. Payne also serves as Chairman of the Audit and Appropriations Committee; chairman of the Ohio Medical Political Action Committee; a director of the Physicians Insurance Company of Ohio (PICO); and chairman of the Board of PICO Life.

A graduate of Ohio State University's College of Medicine, Dr. Payne practices anesthesiology in Ironton where he lives with his wife, Leona, and their five children.

SCOTT R. SWOPE, D.O.
Springboro, Ohio

Scott R. Swope, D.O., has served as team physician for Springboro High School for 20 years and, in addition, serves as a medical advisor for the National Athletic Trainers Association. His outside activities do not end there, however. He is chief and medical advisor of the Clearcreek Life Squad; current member of the Clearcreek Board of Education; assistant coroner of Warren County; and somehow fits in time as a faculty member of the Ohio University College of Osteopathic Medicine.

A graduate of Kirksville College of Osteopathic Medicine in Missouri, Dr. Swope has a family practice in Springboro where he lives with his wife, Judy, and their four children.



Thomas U. Todd, M.D.

THOMAS U. TODD, M.D.
Cincinnati, Ohio

For over 20 years, Thomas U. Todd, M.D., has been team physician at Princeton High School, attending home games, most away games and making himself available 24 hours a day.

But Dr. Todd is just as active in organized medicine. He is presently vice-president of the Ohio Academy of Family Physicians and is editor of its *Ohio Family Physician News*. He is also past president of several organizations, including the Southwestern Ohio Society of Family Physicians.

A graduate of the University of Cincinnati College of Medicine, he opened his family practice in Cincinnati in 1962. He and his wife, Diane, live there with their three children. **OSMA**



Scott R. Swope, D.O.

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Sports medicine

EMOTIONAL CALISTHENICS.

By Gina DiBlasio Cummins

"... Seven-eight-nine-ten, ready or not, here I come!" If these words sound vaguely familiar, you are probably conjuring up childhood memories of kick-the-can and hide and seek. While these games no doubt entertained you (and physically wore you out), it was your emotional self that was getting the real exercise — whether you realized it or not. Your ability (or lack of it), coupled with peer cheers and taunts, affected not only your budding competitive spirit to some degree — but also your future participation and performance in sports.

During the early years you could usually depend on mom to heal the physical and emotional wounds your peers inflicted. The effective way she had of chasing the butterflies away with a quick hug, or instilling confidence with a squeeze of her hand, inspired you to try again. As you grew older, however, you began to rely on others (often less charitable) for psychological support. Parents,

teachers, relatives, peers, coaches and teammates all influenced your mental attitude — and consequently, your athletic performance — by what they said, or left unsaid.

With the current emphasis on the

"The brain operates more efficiently in a healthy body — promoting the old adage of sound mind, sound body . . ."

physical benefits of exercise, more and more people are becoming sport enthusiasts and physicians are consequently treating an increasing amount of sport-related injuries.

Although treating these physical injuries is a physician's primary responsibility, he or she should observe the psychological affect sports may be having on patients as well. Since a patient's mental attitude can directly affect his or her performance, it can consequently increase or decrease the chances for injury and jeopardize emotional well-being.

According to two Columbus psychiatrists, Eugene Arnold, M.D., a child psychiatrist at Ohio State University, and Randy Sansone, M.D., a psychiatrist at Riverside Mental Health Center, understanding both the positive and negative psychological affects sports has on children and adults can be helpful in treating and advising patients.

"Sports are physically beneficial to kids and they may even stimulate healthy growth," says Dr. Arnold. "The brain operates more efficiently in a healthy body — promoting the old adage, 'of sound mind and body.'"



Eugene Arnold, M.D.

“Taking an interest in your child and encouraging him or her is healthy, but expecting a child to be a winner 100% of the time is unrealistic — and psychologically damaging.”

He explains that the psychological benefits from participating in sports are equally as beneficial. One of the most important is the development of a child's social skills. “A child develops qualities such as sportsmanship by learning how to deal with the frustration of missing a shot, striking out or losing a match. By learning how to deal with this frustration, he or she learns how to become a good loser.” On the other hand, a child learns to appreciate the feeling of hard-earned success when he or she finally makes a home run or when the team scores an unexpected victory.

The social skills developed through sports also includes learning to cooperate with fellow teammates — and consequently, others throughout life. “Children learn that the effort they put forth as a team is important and that this cooperation is essential in order to achieve a goal.”

In addition to learning cooperation, he feels that a child's participation in sports enables him or her to learn how to perform under pressure. “This ability to work against the clock can obviously be applied to many areas in life where meeting deadlines is critical.”

Dr. Arnold says that sports also can provide children with the chance to capture their parents' attention. “Participation in sports can reassure children that they are a success in their parents' eyes — providing of course, the parents' have this attitude.”

Unfortunately, many parents do not share this attitude and may be a source of the negative psychological affect sports may have on children. “Many adults are too intent on winning. They keep pushing their child to do better no matter how well he or she is doing. Taking an interest in your child and encouraging him or her is healthy, but expecting a child to be a winner 100% of the time is unrealistic — and psychologically damaging.”

Parents should also avoid forcing their child to participate in a sport with which he or she does not feel comfortable. “Efforts to push a child into a specific sport can backfire — causing a child to become disinterested in any sport.”

Unfortunately, many parents also “live” through their children. They use their child to fulfill dreams that they, themselves, could never accomplish. “Instead of using and exploiting a child for their personal satisfaction, parents should participate in a sport themselves,” notes Dr. Arnold.

“A parent's participation in sports can not only help shift the attention away from a child, but also can be psychologically advantageous to the adult,” says Dr. Sansone. “Since our culture limits the areas where men, in particular, can vent or express their feelings, sports may be of particular value as it is an acceptable arena to display such emotion.”

In addition, sports can give adults a much-needed sense of belonging. “Athletics provide an opportunity for adults to develop a special camaraderie among teammates that they cannot necessarily achieve at the workplace or at the country club. This relationship among team players permits males to share and enjoy physical closeness in a nonthreatening way.”

Both Drs. Arnold and Sansone feel that although sports can be physically and emotionally rewarding, adults should exercise good judgment when selecting a sport in which to interest their child, or when becoming involved in a sport themselves. “A person's age, previous medical history and current physical condition should be taken into consideration before engaging in a particular sport,” says Dr. Sansone. He notes that someone who has led a sedentary life and suddenly begins jogging 5 miles a day is not only risking physical injury, but emotional frustration as well. He emphasizes that a family physician can be especially helpful in advising a

patient in this area.

"Another way aging or out-of-shape adults can avoid emotional frustration with sports is to be flexible — to allow variety when desired, to alter standards when practical, and to explore different facets of the same sport." Dr. Sansone says that instead of trying to duplicate the athletic abilities of your college football days at age 55, one could either become involved with another capacity of the sport, such as coaching, or take an interest in a less physically taxing sport, such as golf. "By channeling your interests into different areas of the sports arena, one can feel a new sense of accomplishment rather than becoming frustrated that 'you can no longer play like you used to.' "

Dr. Arnold suggests that introducing youngsters to noncontact sports such as tennis or golf is another way to prevent age from physically or emotionally interfering with the ability to participate in a sport. "Sports such as these can be enjoyed throughout life with little, if any, decrease in skill and the accompanying frustration."

Finally, both psychiatrists feel that engaging in sports is healthy unless it becomes an all-consuming pastime. "Someone who eats, sleeps and thinks sports is obviously neglecting other important areas of his or her life," says Dr. Sansone. An obsession with anything, including sports, can be psychologically damaging to the individual as well as the entire family.

Spare a patient the psychological damage which involvement with sports may cause by periodically inquiring about your patient's emotional health. Ask a few simple questions while you examine the little leaguer's sprained ankle or the gymnast's twisted ligament. You may find out that he or she is suffering more from a bruised ego, than a bruised body part. **OSMA**

Gina DiBlasio Cummins is a staff writer for the Journal.



Randy Sansone, M.D.

"Another way aging or out-of-shape adults can avoid emotional frustration with sports is to be flexible — to allow variety when desired, to alter standards when practical, and to explore different facets of the same sport."

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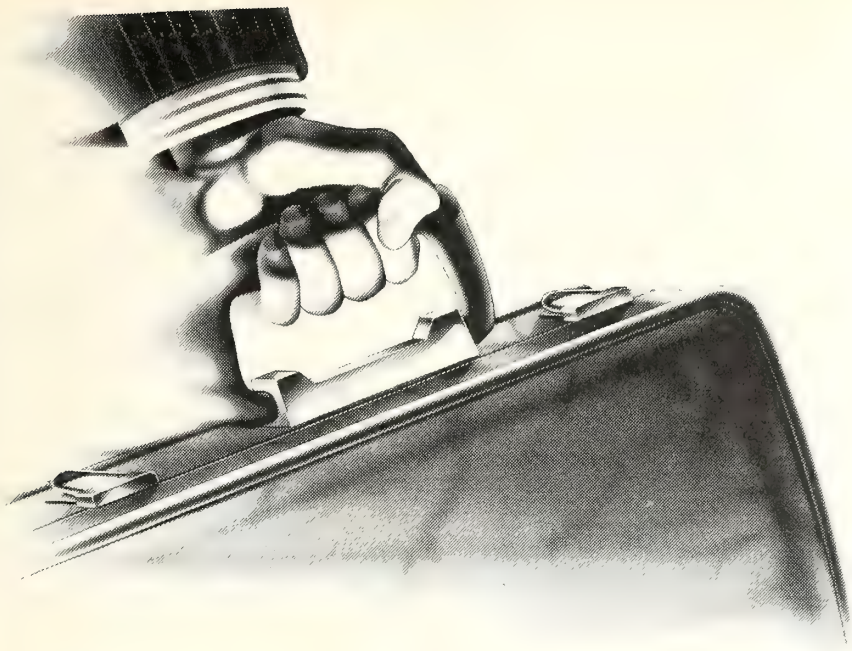
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CONDITIONING.

How to medically advise the “week-end” (and other assorted) athletes.

By Karen S. Edwards

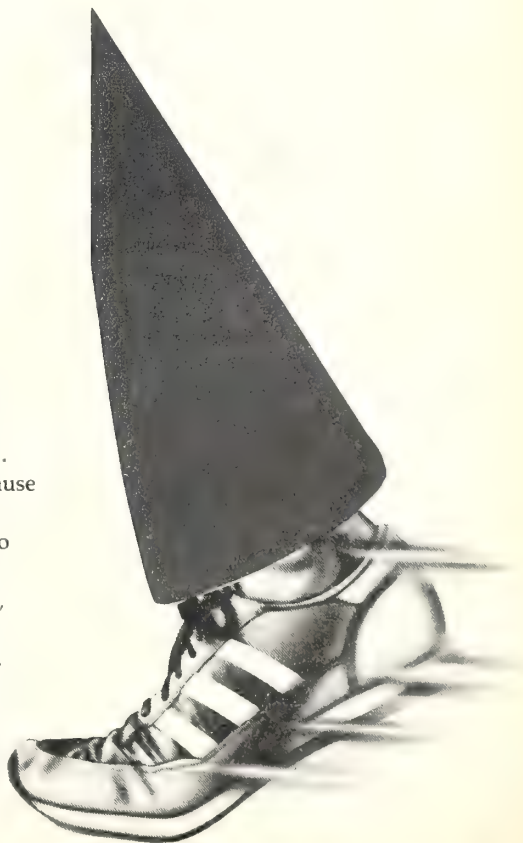
They're coming. Runners . . . joggers . . . weight-lifters. The mailman who quarterback's a team on the weekends, and the eight-year-old who climbs into knee-socks a couple of times a week so he can kick the stuffings out of a soccer ball.

They're coming, alright. And your office is where they are headed.

For the better part of two or three years now there has been a new law of the land. Fitness. Thin is in. Taut muscles, firm bellies, legs that look like they could take on a marathon at the drop of a Nike. So, they stretch, these runners and joggers and weight lifters. They pull, they push, they

work their bodies with all the understanding and tolerance of a Marine drill sergeant. Their bodies gleam . . . their muscles scream . . . and that's where you come in, because you're the doctor, and you should know just what it is they've *done* to deserve all this aching punishment.

Telling athletes how to condition, however, is still one of the biggest mysteries of the medical profession. There are so many variables, and those who practice in the area of sports medicine soon learn that the “hard and fast” rules are about as permanent as an ice-pack on a radiator.



"As medicine advances, so does our knowledge about the proper way to condition," says Delphis Richardson, M.D., a Columbus pediatrician whose tall, slim frame would make him look equally "at home" on a basketball court.

Basketball was, in fact, one of many sports Dr. Richardson enjoyed as a youth — and still does enjoy. His interest in sports medicine began just as early. As a medical student, with some background as a basketball player for Ohio State University, the area seemed a natural one for him. He became involved, then, with the care of high school athletes, and even now fits in some extra duty along this line as a team physician for Columbus' Linden-McKinley and Hamilton Township's schools. In addition, he serves as a member of the Ohio State Medical Association's Sports Medicine Committee.

Dr. Richardson would concur that America has recently begun a real push to shape up.

"The whole country has become more health oriented," he says, "and fitness and sport-participation are inevitable corollaries."

Health spas, like Holsteins, dot the countryside — while in the cities, places of business are converting

auditoriums to gymnasiums, bringing in equipment that Charles Atlas would covet.

"People have a real image, now, of what the body is supposed to look like," he adds, "Trim, lithe, athletic, full of energy."

As Dr. Richardson theorizes, it's an image brought on by several things.

"The whole area of professional

"People have a real image, now, of what the body is supposed to look like — trim, lithe, athletic, full of energy"

sports has done a lot to bring this about. Pro sports have grown — they have their own cable station, their own night on national network television — the athletes, themselves, are all over the news, even the commercials. So, people are seeing these athletic bodies more and more and may be subliminally using them as a role model for their own bodies."

Dr. Richardson warms to the subject.

"The coverage of the Olympics has done even more along this line. We're seeing ordinary people — amateurs — in top physical condition, and *young*. In Europe, children are conditioned for sports early, so when we sit down to watch the Olympics, we're seeing all these young people, in great shape, competing in world-class events."

And parents are getting the message, even if Johnny isn't. But, in most cases, Johnny is.

"I don't have any figures, but in my practice, I've seen the number of children participating in organized sports grow and grow."

Admittedly some of these children are being pushed by competitive parents.

"But children between the ages of 7

and 10 are natural athletes. Their bodies are still supple and flexible, and given the opportunity, this age group will compete. They want to compete," Dr. Richardson says.

Statistics show that participation in organized sports results in far fewer injuries than when the children are allowed to have a free run. And that all seems to boil down, again, to the subject of conditioning.

But conditioning is not an easy subject for any physician — even one familiar with sports medicine — to address.

"If you want a definition, a conditioned body is one where all the systems — the musculo-skeletal, cardiovascular, pulmonary — are working at peak efficiency in harmony with each other," Dr. Richardson says.

Still, getting to that state is where the controversy lies. And, as hinted earlier, there are a lot of myths and misconceptions about the proper conditioning of an athlete.

"We've had to change our view on several things," Dr. Richardson points out. "For example, for a long time, we were advising diabetics and asthmatics not to participate in sports at all."

That game plan has changed, however, and as long as the patient is keeping his or her problem under control with the proper medication, "there's no reason in the world why they can't participate in any sport they choose," Dr. Richardson says.

Another standby that is changing is the annual pre-participation health exam. It's still a controversial area, but Dr. Richardson is one of those who feels that "interval exams" are apt to be the wave of the future.

"The feeling is that, short of areas like the neck, back, knees and feet which do need to be checked regularly, there simply aren't enough problems occurring in the young athlete to warrant an annual exam." So, health exams might be given to the student only every few years.

Of course, one of the reasons problems "just aren't occurring" is that medicine has made some strides in the area of training the athlete.



"We know more, now, about how muscles work, and what effect aerobic activity has on the body," Dr.

Richardson says. "The whole area of isokinetics is a new, dynamic subject that is being explored."

Isokinetics is the study of motion, and its relationship to the wide range of joints in the body. In essence, what it does is stress flexibility to the athlete.

"The adult, professional football player rarely receives any exercise that promotes his flexibility. Strength and agility, yes. Flexibility, no," Dr. Richardson says. "So medicine is making strides to promote this kind of training — at all levels."

Such scientific advances as nuclear medicine are also having an effect on the training aspects of the athlete.

"We know now how long it takes to empty the stomach of certain foods, so pre-game meals — which have a history of misconceptions going back to the Roman arena — are being restructured to give the athlete the food he or she needs, based on what it's needed for," Dr. Richardson says.

For example, with competitive, marathon runners, pancakes make a better breakfast than steak.

"It's called 'carbohydrate-loading.' The athlete stashes away pancakes a few hours before a race because we know the body will store the calories and burn them quickly, during the race, when they're needed."

Which is exactly why eating a candy bar before the race is all wrong.

"Sugar burns quickly. What you get is a quick rush of energy, then a drop in your blood sugar, which leaves you with absolutely nothing."

However, if you're an oar man on a rowing team — that candy bar may be just what you need.

"The largest amount of calories I've ever heard one person needing is a member of a competitive rowing team who needs about 5,000 calories a day."

And that means "junk food" — candy bars, potato chips, beer — and lots of it.

"Normally, we try to steer clear of

this kind of food, but in some instances, it's necessary," says Dr. Richardson.

It's all relative — like the amount of bulk you need.

"The term 'over-conditioned' is really a contradiction in terms," Dr. Richardson says. "Conditioned means you've reached that peak state, so how can you over-condition?"

"If you want a definition, a conditioned body is one where all the systems — the musculo-skeletal, cardiovascular, pulmonary—systems are working at peak efficiency in harmony with each other."

However, people like professional football players have really developed more bulk than they need. What they've sacrificed is that flexibility we've already discussed," he adds.

Still, medicine's increasing knowledge is sometimes ahead of itself in the world of sports.

"For five or ten years now we've had a scale, known as the 'Tanner Scale' which measures the maturation level of pre-adolescents and adolescents. Actually, school teams ought to be drawn up from this scale, because children mature at such different rates. We've learned, for example, that a 14-year-old who has no pubic hair yet is no match in strength for a 14-year-old who does. Therefore, it's really not fair to divide teams up according to age, but practically, there's no choice. New York tried an experiment which

attempted to divide teams by the Tanner scale — but it turned out to be confusing and prohibitively expensive," Dr. Richardson says.

And the controversy of that — as with other subjects in this area — goes on. So, 14-year-olds play 14-year-olds . . . the mailman who quarterbacks on weekends is still running plays . . . and the search for the proper conditioning technique goes on. Thanks to the area of sports medicine, there is a lot more you can tell your athletically-inclined patients about getting in shape than you used to — and that's good.

Because all those Americans out there who are looking for your advice on how to get and keep physically fit aren't just walking to your office. They're running.

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.



JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

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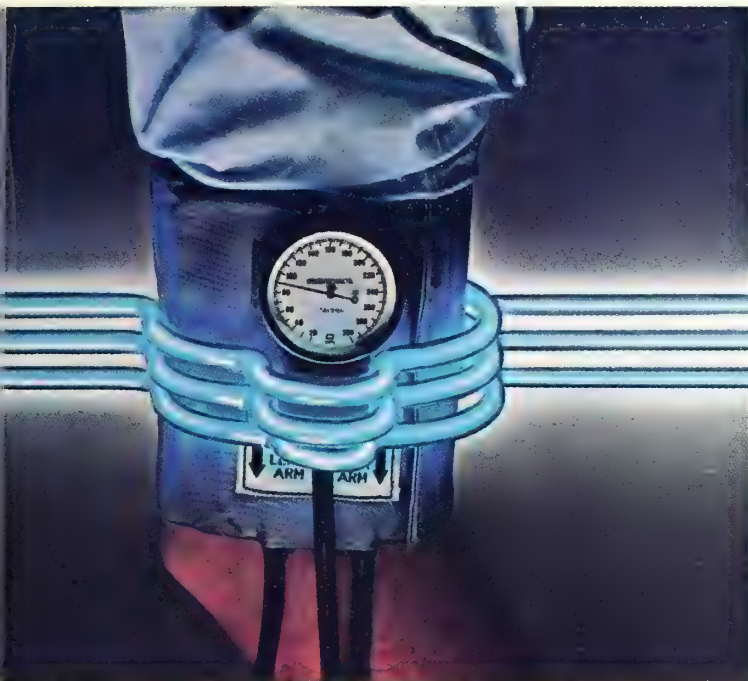
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INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



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Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg



120 mg



160 mg

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Please see next page for brief summary of prescribing information.

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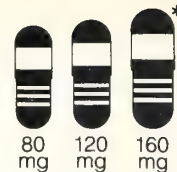
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)
INDERAL[®] LA BRAND OF propranolol hydrochloride

(Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal, as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General. Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypotensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of Inderal LA capsules is a registered trademark of Ayerst Laboratories.

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UNDERSTANDING DRG's.

PART II

By Rebecca J. Doll

Editor's Note: In last month's Journal, we reviewed the background behind diagnosis related group reimbursement (DRG). This month, we take a look at the experience in one New Jersey hospital and at what various hospitals throughout the state are doing to prepare for phase in of the DRGs, which begins next month.

The only sure thing one can say about the concept of diagnosis related group (DRG) reimbursement is that it's the law — a law that hospitals and thus, physicians, have to live with. Just *how* to live with it seems to be the question.

Phase in of the DRG system of reimbursement will begin next month. At that time, hospitals will begin the transition to a system that pays Medicare bills, which account for about 37% of the hospital revenue in Ohio, according to the Ohio Hospital Association, on the basis of diagnosis rather than cost. Just how this new concept will affect the health care delivery system is anyone's guess — and guesses and theories abound. Frantic attempts to make some sense of the DRG system have sent hospital and medical organizations throughout

"I think if anything's true about the DRG system, it's that it will be absolutely imperative that a physician and the hospital document, as fully as possible, everything there is to say about a particular case."

the state scrambling to set up educational seminars for administrators, medical record keepers and physicians.

Experience with DRGs is limited primarily to about 26 test hospitals. One such hospital, Overlook in Summit, New Jersey, has been experimenting with DRGs for nearly three and a half years. Overlook's Quality Assurance Officer, Warren Nestler, M.D., was in Ohio last July at the request of the Greater Cleveland Hospital Association to discuss his hospital's experience with several Cleveland area physicians. Included in the videotaped discussion were: Theodore J. Castele, M.D., chief of radiology at Lutheran Medical Center who acted as moderator; Robert Post, M.D., coordinator of professional

“Clinicians must eliminate unnecessary services, complications which are preventable, inefficiently performed services and unreliable records. They must recognize that to allow these things to continue is bad medicine and we can no longer afford bad medicine.”

affairs at University Hospitals in Cleveland; Dean Wochner, M.D., chief of staff at Metropolitan General Hospital and Highland View Hospital; and Thomas Gretter, M.D., quality assurance officer at the Cleveland Clinic. Earlier, he met with the staff of Cleveland's Deaconess Hospital.

An outspoken advocate of DRGs, Dr. Nestler pronounces the system “financially, clinically and behaviorally rational.”

“The DRG system was set up on the basis of 1.4 million discharge abstracts. Analysis of the abstracts indicated a high correlation between cost and length of stay. Under the DRG system, we can, for the first time, compare hospitals on the basis of case rather than cost.” This, says Dr. Nestler, adds an economic incentive to provide cost efficient care without reduction in necessary services or quality.

Not everyone agrees.

“We really don't know what effect DRGs will have on services or quality care,” says Dr. Gretter. “In theory, we will be able to see what it actually costs from a clinical standpoint for the first time ever. From that vantage point, it stands tremendous potential to cut costs just by enabling us to really see the costs of various procedures and services. But, he adds, “I've experienced situations whereby people begin to think on a cost basis and things don't get done and people may suffer the consequences. But under DRGs, I just don't know what will happen because I don't think anyone knows just how strict doctors and hospitals are going to be.”

Others take a stronger stand.

“Medicine is a profession,” says Isidoro Amigo, M.D., chief of staff at Deaconess Hospital. “Once you go into it as a business, it doesn't work. I think, in the long run, DRG, could negatively affect quality of care. There will be pressure from the hospital and insurance carriers to send the patient home early and once you take the freedom away from a physician to

think only about the patient, it's not good medicine anymore and it could be damaging to the patient.”

According to Dr. Amigo, the executive board of the medical staff felt so strongly about the negative potential of DRGs, it voted its opposition to it.

“We believe very strongly that we practice good medicine and keep good records. We don't like DRG, but we recognize it's the law and we'll have to live with it.”

“Keeping good records” is one of the few things about DRGs on which nearly everyone can agree.

“I think if anything's true about the DRG system it's that it will be absolutely imperative that a physician and the hospital document, as fully as possible, everything there is to say about a particular case,” says Dr. Castele.

Recognition of that fact has sent many hospitals in search of a new record keeping system. At Metropolitan General in Cleveland, where Dr. Wochner is chief of staff, a new recordkeeping system is being reviewed which will take into consideration the special problems an institution such as Metro General has due to the fact that residents are often responsible for keeping medical records.

“I think all hospitals have trouble with recordkeeping at some time or another, but when you have a big metropolitan hospital that depends a great deal on residents who may rotate in and out in a two-month period, and you've got a system such as DRG, there is great potential for problems down the road,” says Dr. Wochner.

To minimize the problem, Metropolitan General intends to hire a DRG Coordinator to see that records and data focus and develop around DRGs. It also recently revised its quality assurance plan which includes utilization review to give it more flexibility and is also thinking of establishing patient care committees in

each department.

Yet, while nearly everyone agrees that good recordkeeping will be mandatory under DRG, some fear potential misuse of records.

"If we aren't careful about the use of those records, we could seriously damage our system of cataloging disease," warns Dr. Gretter. "For example, what would happen if third parties decided not to reimburse for cancer anymore? In effect, cancer, as a diagnosis, would be wiped out. We would begin to diagnose it as something that was reimbursable. We end up juggling disease categories for reimbursement purposes and there goes our statistical catalogue on many diseases."

Others worry that records may be used to force a physician out of a hospital. Yet Dr. Nestler calls it, "an opportunity in disguise."

"Clinicians must eliminate unnecessary services, complications which are preventable, inefficiently performed services and unreliable records. They must recognize that to allow these things to continue is bad medicine and we can no longer afford bad medicine."

But, Dr. Nestler adds, it won't be the records per se that may cause the physician to change his or her behavior pattern or be forced out. It will, in all probability, be peer pressure to conform to the norm.

"What happens is a doctor practices a certain number of years and along comes this new system which dictates a change. The doctor wonders why change now since the old system has worked for years. But if the doctor's colleagues are responding to the new system and it's working for them and he or she is causing problems for the group, there's no question that pressure from colleagues is going to change that doctor's mind. It is, without a doubt, the most effective way to effect change."

Others agree.

James P. Fitzgerald, President of Good Samaritan Hospital in Dayton,

a hospital noted for its successful attempts at cost containment, says the risk right now is to the hospital. "And there may come a time when management will have to say to a physician, 'look, doctor, here's your pattern of behavior. It's outside of usual practice behavior and you know, maybe we can't afford you at this hospital any longer.'" But, he adds, "I think the conflict potential is greater between physician and physician than between administration and physician. Most physicians are going to respond quicker to peer pressure than to administrative pressure. Plus, I think you're going to see loyalty of physicians to a particular hospital increase as physicians find it to their benefit and that of their patients to stick to one or two hospitals where relationships can be developed and loyalties strengthened."

Peer pressure and recordkeeping notwithstanding, if DRG is to be successful, the key will be cooperation among all involved, but especially the administration and the medical staff. And, as Hugh Kurkle, administrator of Holzer Hospital in Gallipolis puts it, that cooperation also may mean compromise.

"I think what the board of trustees, the medical staffs and the administrators all have to remember is what we're really talking about here is survival. Most of what we know about DRGs is theory and conjecture at this point. I think we can survive it, but it's going to take a lot of statesmanship on the part of everyone involved."

How will all of this affect patients?

"Due to the phase-in nature of the system, I don't think it will affect patients at all, initially," says Newkirk. "Down the road we may find that certain services won't be available in the same form. For example, a clinic may have to cut its operating days from five to three." And, he adds, "we may see some costs being passed on."

continued on page 697

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Understanding DRG's, Part II

continued

That possibility worries physicians and administrators alike. There is general agreement that patients carrying private insurance already are subsidizing the system and that it may become worse under DRGs. There is also concern that DRGs may increase the potential for a two-class system of health care.

"Under this system, I see a real potential for dumping, especially in metropolitan areas," says Fitzgerald. "We may begin to see Medicare mills similar to those we have seen for Medicaid."

Others, however, feel the system may benefit patients in the long run.

"This system may force a healthy change on the part of larger hospitals," says Dr. Wochner. "They will have to improve their outpatient departments and their ties to physicians' services in the community. They will have to relate closer to

nursing homes and other health care groups which cater to the elderly. As far as cost shifting to other carriers is concerned, it may happen, and if it does, I think they, too, will set up a DRG system."

That has already happened in Kansas where Blue Cross and Blue Shield's DRG system goes into effect January 1, 1984. According to the *Blue Cross/Blue Shield Consumer Exchange*, July 1983, all participating hospitals and physicians will be reimbursed based on a DRG system. The publication says the new reimbursement system "will encourage cost effective care in a state with one of the nation's highest hospital utilization rates and it will minimize future increases in subscriber rates." Rate increases for 1984 are predicted to be in the neighborhood of 10 to 15% as compared to a 28% rate increase in 1982.

Among all of the theories and frustrations, a wait-and-see attitude prevails. At the time of this writing, rules governing the DRG system had not been promulgated. Until they are, hospitals and physicians will remain in a situation which calls for playing the game and learning the rules all at the same time.

Rebecca J. Doll is an Associate Executive Director of the OSMA, and Director of the Department of Communications



Preparing for a videotape on DRG's to be shown at Cleveland area hospitals are (from left to right): Theodore Castele, M.D., Cleveland, Warren B. Nestler, M.D., Quality Assurance Officer, Overlook Hospital, Summit, New Jersey, and Thomas Gretter, M.D., Quality Assurance Officer, Cleveland Clinic.

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The Physician and Ohio Law

"The Physician and Ohio Law" is being introduced as a column in the Journal in response to the growing number of legal questions which are addressed to OSMA from the county societies and OSMA members. The column will focus on legal issues — such as developing medical-legal areas and Ohio Supreme Court decisions — and on regulatory matters which affect physicians (for example, State Medical Board actions and Department of Health activities). The OSMA is registered as a 501 (c) (6) corporation with the Internal Revenue Service. To maintain such standing, the Association's activities must promote the common interest of the membership rather than provide specialized services to individuals. Consequently, this column will be devoted to general legal questions of interest to the membership. Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

Medical Supervision Who's in charge?

The degree and type of medical supervision necessary has recently come under review by the Medical Board in cases involving emergency medical technicians, nurse anesthetists and nurse midwives.

Emergency medical technician (EMT) supervision was raised in the context of the decision made by an EMT not to transport a victim. William R. Roush, M.D., of Akron had asked the Board to consider whether the decision not to transport was a medical decision and thus one which could only be made by a physician. Situations which regularly produce a decision not to transport include: false alarms (no medical emergency, e.g. a minor cut); a victim dead at the scene (coroner's case); or an individual who needs transportation to a physician's office or hospital for a previously scheduled appointment or admission. In other cases, a determination may be made that transport is unnecessary based upon the symptoms of the victim.

The Board heard extensive testimony from interested parties as to the need for on-line communication with a physician versus the adequacy of standing orders found in written protocols previously approved by a physician oversight committee. To date, the Medical Board has not delineated the adequate level of physician responsibility.

* * *

Blue Shield (OMIM) asked the Board to clarify who can be a supervising physician for purposes of the nurse anesthetist statute, 4731.35, ORC and what degree of supervision is necessary to meet the statutory requirement. OMIM explained that the organization is attempting to establish guidelines for direct reimbursement in instances where an anesthesiologist is not the billing party.

The Ohio Society of Anesthesiologists, the Ohio Association of Certified Registered Nurse Anesthetists, and the Ohio State Medical Association provided information to the Board. The Medical Board plans to respond to Blue Shield at its August or September meeting. It may expand its response to a formal policy position further defining the supervision of registered nurse anesthetists.

* * *

The Ohio Department of Public Welfare, pursuant to federal regulations which require state Medicaid programs to establish a direct reimbursement mechanism for registered nurse-midwives, asked the Medical Board for guidance as to the nurse midwife's scope of practice. The Board responded by issuing guidelines on nurse midwives in January 1983 (included in the new *Physician's Guide to Ohio Law*). Subsequent to the Board's action, the Welfare Department proposed rules for nurse-midwife reimbursement for Medicaid.

The Welfare Department's rules establish a procedure in which either the nurse midwife or the supervising physician is reimbursed directly for the procedure(s). The physician's charge for supervision of the nurse midwife as well as the hands-on work performed by the nurse midwife are part of the reimbursed amount. The percent of reimbursement for each is determined by the nurse midwife and the physician, rather than by the Department.

Temporary certificate policy clarified

Editor's Note: In February 1983, the Ohio State Medical Board issued a

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memorandum to all hospital medical directors concerning the granting of temporary certificates to interns, residents and fellows. The section discussing countersignatures was unclear, so the Medical Board issued the following clarification on July 11, 1983:

Any patient charts and patient orders issued by the trainee must be countersigned by the appropriate supervising physician, as follows:

1. Within twenty-four hours after patient admission, the initial patient medical record or document will be countersigned by the responsible, supervising physician, designating him as such.
2. Upon discharge of the patient, the discharge note and/or documents also will be signed by the responsible, supervising physician for that particular patient.
3. For the time period between admission and discharge, all countersignings should be

performed in accordance with the rules or bylaws of the particular hospital or institution involved.

Proper supervision over all trainees and unlicensed personnel by those who are licensed in supervisory positions must be maintained under Ohio's medical practice act. The countersignature requirements should assist in ensuring proper supervision over all unlicensed interns, residents or fellows in approved post-graduate training programs.

Ohio Supreme Court decision gives lawyers dose of the same medicine

In a terse, four-paragraph opinion, *Skidmore & Hall v. Rottman*, the Ohio Supreme Court applied the discovery rule to medical malpractice cases. Citing the *Oliver* case, which applied the discovery rule to medical

malpractice cases (see the August issue of the *Journal*), the Court overruled all prior cases which stated the one-year statute of limitations for legal malpractice began to run from the cessation of the attorney-client relationship. With this latest opinion, the Court again applied the new principle to Ohio that the statute of limitations begins to run only when the client discovers or should have discovered the alleged malpractice.

D. Brent Mulgrew, J.D., and Catherine Costello, J.D. are in OSMA's Department of Legal Services and serve as OSMA's Staff Counsel.

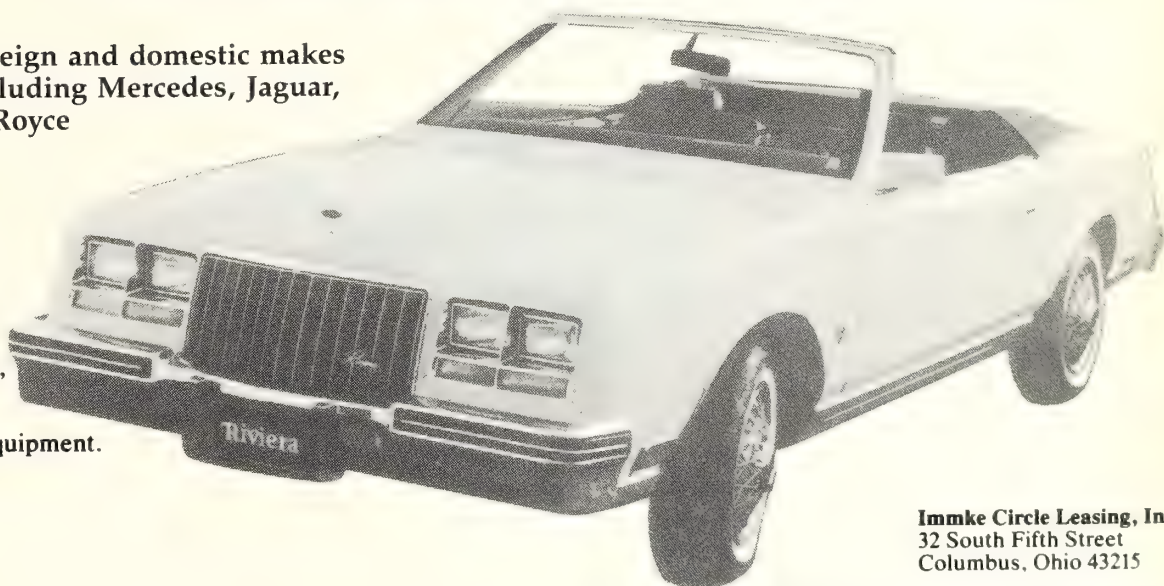
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Continuing Education Programs

September

CONFERENCE ON MEDICAL CONFIDENTIALITY VS. THE PUBLIC INTEREST: LAW, MEDICINE & THE MEDIA:

September 9; Marcum Conference Center, Miami University, Oxford; sponsor: College of Arts and Science, Miami University; cosponsor: Wright State University School of Medicine; 6 credit hours; fee: \$75, \$35 for students; contact: Andrew Kerek, College of Arts and Science, Miami University, Oxford 45056, phone: 513/529-4531.

44TH ANNUAL MEETING OF THE OHIO SOCIETY OF

ANESTHESIOLOGISTS: September 9-11, 1983; Columbus Marriott Inn North, Columbus, Ohio; 9 hours Category I credit; sponsored by the Ohio Society of Anesthesiologists, Inc. and the Ohio State Medical Association; fee: OSA member — no cost; non-member physician — \$50; non-member allied health personnel — \$50; housestaff — no cost; contact: Ms. Vickey McVay, Ohio Society of Anesthesiologists, 600 South High Street, Columbus, Ohio 43215, (614) 228-6971.

NEUROSURGICAL

EMERGENCIES: September 22; Finnegan Auditorium, St. Elizabeth Hospital, Youngstown; sponsor: St. Elizabeth Hospital Medical Center; cosponsor: Northeastern Ohio Universities College of Medicine; 3 credit hours; No fee; contact: Rashid Abdu, M.D., St. Elizabeth Hospital, 1044 Belmont Avenue, Box 1790, Youngstown, OH 44501, phone: 216/746-7211, Ext. 3124.

THE UNITED STATES SECTION, INTERNATIONAL COLLEGE OF SURGEONS, will have its XII Western Hemisphere Congress in Cleveland, September 25-September 28 at

Stouffer's Inn on the Square. For further information, contact: Jorge Medina, M.D., 36100 Euclid Avenue, Willoughby, Ohio 44094.

ADOLESCENTS IN TURMOIL: A CLOSER LOOK: September 26; Quality Inn, 4900 Sinclair Road, Columbus; sponsor: Harding Hospital, Worthington; 6 credit hours; fee: \$50; contact: Symposia Registrar, Harding Hospital, 445 East Granville Road, Worthington 43085, phone: 614/885-5381, ext. 326.

WORKSHOPS ON TREATMENT OF ADOLESCENTS; September 27; Harding Hospital, Worthington; sponsor: Harding Hospital; 5.5 credit hours; fee: \$40; contact: Symposia Registrar, Harding Hospital, 445 East Granville Road, Worthington 43085, phone: 614/885-5381, ext. 326.

October

ARTHRITIS AND THE ELDERLY: October 13-14; Bond Court Hotel, Cleveland; sponsor: Center on Aging and Health, Case Western Reserve University; 12.75 credit hours; fee: \$125, \$60 for students; contact: Marie Haug, Ph.D., Center on Aging and Health, Case Western Reserve University, Cleveland 44106, phone: 216/368-2692.

PERIOPERATIVE MEDICINE — EVALUATION & MANAGEMENT OF MEDICAL PROBLEMS IN THE SURGICAL PATIENT: October 13; Holiday Inn, I-75 & St. Rte. 55, Troy; sponsor: Dettmer Hospital; 6 credit hours; fee: \$60; contact: Gerard F. Wolf, M.D., 145 Sunset Drive, Piqua 45356, phone: 513/773-8323.

11TH ANNUAL MEETING OF THE OHIO CHAPTER, AMERICAN COLLEGE OF PHYSICIANS AND THE OHIO SOCIETY OF INTERNAL MEDICINE: October 13-15, 1983; Quaker Square Hilton, Akron, Ohio;

12 hours Category I credit; sponsored by Ohio Chapter, American College of Physicians and the Ohio Society of Internal Medicine; fee: ACP or OSIM members — \$100; ACP and OSIM member — \$90; non-member physician — \$125; housestaff — no cost; contact: Ms. Vickey McVay, Ohio Society of Internal Medicine, 600 South High Street, Columbus, Ohio 43215, (614) 228-6971.

DO I NEED AN OFFICE COMPUTER? October 15; The Westin Hotel, Cincinnati; sponsor: Bethesda Hospital, Cincinnati; 6 credit hours; fee: \$95; contact: Bethesda Hospital, Medical Staff Education, Location 00348, Cincinnati 45264, phone: 513/569-6339.

VASCULAR SURGERY — 1983: October 27-28; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$190, \$95 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

November

SELECTED TOPICS IN LABORATORY MEDICINE: November 3-4; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$150, \$75 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

CINCINNATI CANCER CONFERENCE II: G.I. MALIGNANCIES: November 4-5; Westin Hotel, Cincinnati; sponsor: Bethesda Hospital; cosponsors: University of Cincinnati College of

Medicine and The American Cancer Society; 11-1/4 credit hours; fee: \$170; contact: Thomas O'Connor, Medical Staff Education, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513/569-6323.

CURRENT CONCEPTS IN THE DIAGNOSIS AND TREATMENT OF EPILEPSY: November 9-10; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$140, \$70 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

PERSPECTIVE IN THE CARE OF THE DEFECTIVE NEWBORN: MEDICAL, ETHICAL, LEGAL, PARENTAL, AND NURSING: November 11; Fawcett Center for Tomorrow, Ohio State University; sponsor: Children's Hospital, Columbus; 5 credit hours; fee: \$125, \$75 for allied health professionals; contact: Educational Program Coordinator, Children's Hospital, 700 Children's Drive, Columbus 43205, phone: 614/461-2914.

F. MASON SONES DEDICATION COURSE: November 12; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: \$80, \$40 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

GASTROENTEROLOGY UPDATE — 1983: November 16-17; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$140; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106,

phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

ORTHOPAEDIC INFECTIONS: November 17; Finnegan Auditorium, St. Elizabeth Hospital, Youngstown; sponsor: St. Elizabeth Hospital; cosponsor: Northeastern Ohio Universities College of Medicine; 3 credit hours; No fee; contact: Rashid Abdu, M.D., St. Elizabeth Hospital, 1044 Belmont Avenue, Box 1790, Youngstown OH 44501, phone: 216/746-7211, Ext. 3124.

4TH ANNUAL SYMPOSIUM ON COLORECTAL SURGERY: November 18-19; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 10 credit hours; fee: \$150, \$75 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

NEWER APPROACHES TO BIOLOGICAL TREATMENT OF PSYCHIATRIC DISORDERS: November 30; Bunts Auditorium, Cleveland Clinic; 6 credit hours; fee: \$70; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

Impaired Physician Conference

OSMA will sponsor the "Third Ohio Conference on the Impaired Physician" on October 15-16, 1983, at the Sheraton Inn North in Columbus.

For additional program information and registration materials contact Physician Effectiveness Program, OSMA, 600 S. High St., Columbus, Ohio 43215.



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carry out the charitable, educational, or scientific purpose in the name of the fund.

Memorial gifts may be made payable to the Ohio Medical Education & Research Foundation (OMERF) and sent to the OSMA office. All gifts are acknowledged both to the donor and to the family of the deceased.

In Living Memory

OMERF wishes to thank the individuals and groups who have contributed in memory of Perry Ayres, M.D.

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"Orphan Drugs" now available to treat kidney stones

The general treatment of urolithiasis is yielding to specific agents for particular types of kidney stones, according to a report in a recent issue of the *Journal of the American Medical Association*. Two new agents have been approved by the Food and Drug Administration since last December and a third is expected to receive approval soon. The new agents are sodium cellulose phosphate (SCP, Calcibind), an ion exchange resin, for treatment of one type of calcium stone, and acetohydroxamic acid (AHA, Lithostat), a bacterial enzyme blocker for prevention of so-called struvite stones. The third agent, potassium citrate, inhibits the formation of stones associated with abnormally low urinary levels of citrate.

Obituaries

BENJAMIN ABRAMSON, M.D.,
Columbus; Chicago College of
Medicine and Surgery, 1916; age 91;
died June 26, 1983; member OSMA
and AMA.

JOSEPH J. AGRESTA, M.D.,
Steubenville; Wayne State University
School of Medicine, 1966; age 51; died
June 7, 1983; member OSMA and
AMA.

HARRY T. BOWMAN, M.D.,
Canton; University of Pittsburgh
School of Medicine, 1961; age 47; died
July 3, 1983; member OSMA and
AMA.

GORDON J. HARPER, M.D.,
Bellevue; Hahnemann Medical College
and Hospital, 1973; age 35; died June
11, 1983; member OSMA and AMA.

FRANK S. HOUSER, M.D.,
Cleveland; Case Western Reserve
University School of Medicine, 1944;
age 63; died June 9, 1983; member
OSMA.

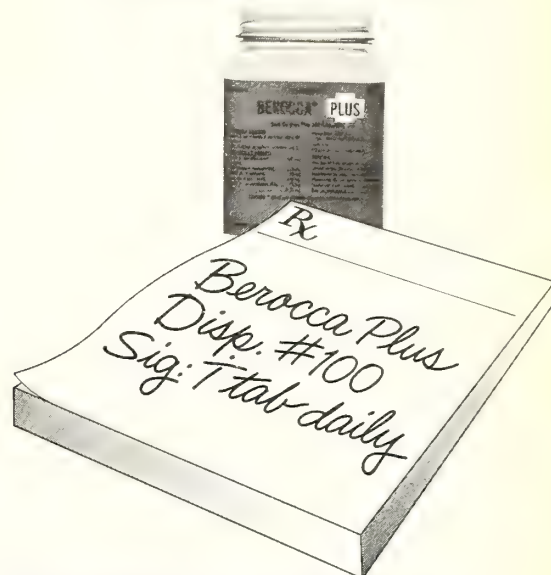
JAMES B. KATZ, M.D., Cleveland;
Ohio State University College of
Medicine, 1956; age 53; died June 15,
1983; member OSMA and AMA.

WILLIAM A. LIESER, M.D.,
Canton; Case Western Reserve
University School of Medicine, 1941;
age 67; died May 23, 1983; member
OSMA and AMA.

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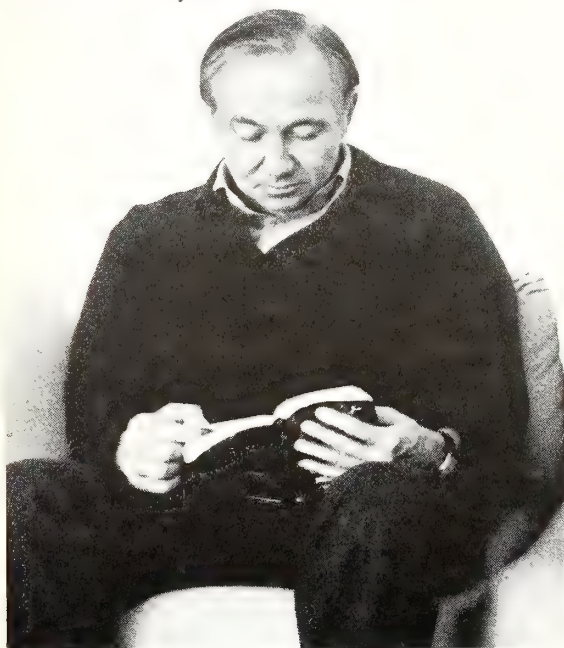
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*Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237.

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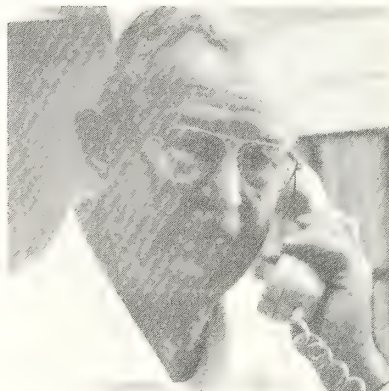
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ROCHE

Obituaries

continued

NORMAN L. MARXEN, M.D., Van Wert; Ohio State University College of Medicine, 1948; age 58; died June 24, 1983; member OSMa and AMA.



Maternal health proponent dies suddenly

ANTHONY RUPPERSBERG, JR., M.D., a Columbus obstetrician-gynecologist for nearly 40 years, died this past July of an apparent heart attack while he was on vacation in Florida.

Dr. Ruppertsberg had retired just last year from the Ohio State Medical Association's Maternal Health Committee which he had chaired for 28 years. One of that committee's projects, the Ohio Maternal Mortality Study, had been developed by Dr. Ruppertsberg.

A member of the Ohio State Medical Board since 1970, Dr. Ruppertsberg had served as the board's secretary since 1973. In addition, he was professor emeritus of obstetrics and gynecology at Ohio State University and taught at Grant Hospital.

Dr. Ruppertsberg was recently presented with a plaque recognizing his thirty-five years of service to women and infants in Franklin County and Central Ohio by the Columbus Obstetric/Gynecologic Society.

He is survived by his wife, Adele, and a son, Anthony J. Ruppertsberg, III.



CLINICAL NOTES

Edited by Karen S. Edwards

Anatomic changes in PTA described

Percutaneous transluminal angioplasty (PTA), a technique using a tiny balloon-tipped catheter to dilate obstructed coronary arteries, also was recently used to dilate obstructed coronary artery bypass grafts. The anatomic changes that occur during the graft PTA are described for the first time by a group of physicians from

the University of California at Irvine Memorial Hospital Medical Center, Long Beach. They report finding tears in the inner lining of the graft vessel and entrance of the fatty plaque into the vessel wall, and speculate that tearing of the vessel wall, rather than compression of the fatty plaque, may be the mechanism by which PTA widens an obstructed vessel.

— *Journal of the American Medical Association*
Vol. 249, No. 24, pg. 3347-3349

New antidepressant shows promise

Depressed patients may get relief faster and with fewer side effects with a new drug called alprazolam than with the tricyclic antidepressants that are currently the mainstay of therapy, according to an interstate group of researchers headed by John P. Feighner, M.D., of the University of California, San Diego. In a double-blind study, the authors found alprazolam to be at least as effective as the tricyclic antidepressant imipramine in relieving de-

pression, more effective in relieving some physical complaints and faster in onset of action.

— *Journal of the American Medical Association*
Vol. 249, No. 22, pg. 3057-3064

Prospective radial keratotomy study

A first prospective evaluation of radial keratotomy reports good short-term results for the new operative procedure aimed at correcting myopia.

Radial keratotomy is a surgical procedure in which a series of incisions is made in the cornea from the outer edge toward the center in spoke-like fashion. It is done to correct an error of refraction that causes rays of light entering the eye to be brought to a focus in front of instead of on the retina.

"Although the predictability of radial keratotomy is controversial, this study has shown that radial keratotomy can be effective for reducing myopia over a range of approximately

continued on next page

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Clinical Notes

continued

10 diopters (a measurement of refractive power of a lens)," report Peter N. Arrowsmith, M.D., of Nashville's Parkside Surgery Center, and colleagues.

— *Archives of Ophthalmology*
Vol. 101, No. 6, pgs. 873-882

Drug prevents recurring eye hemorrhages after injury

Researchers at the University of Illinois Eye and Ear Infirmary, Chicago, have demonstrated conclusively the safety and efficacy of a heretofore neglected treatment to prevent recurring hemorrhage in an injured eye.

Their report shows that aminocaproic acid administered in precisely calculated doses can significantly reduce the incidence of secondary hemorrhage

after blunt (nonperforating) trauma to the eye. The drug, a synthetic amino acid, works by inhibiting dissolution of blood clots and consequent reopening of ruptured ocular blood vessels, according to John J. McGetrick, M.D.

Aminocaproic acid therapy to prevent secondary hemorrhages following ocular trauma was first described by other investigators in 1976 but has not gained widespread acceptance in the medical community despite subsequent reports of its efficacy. With the University of Illinois report, writes another of its authors, Morton F. Goldberg, M.D., in an accompanying editorial, "the burden of proof now shifts to those who claim that it should not be used in routine management of this disease."

— *Archives of Ophthalmology*
Vol. 101, No. 7, pgs. 1031-1033

Brain hemorrhage in preemies

A premature newborn's risk of brain hemorrhage may be related to its position during delivery along with either its gestational age or the duration of labor, according to Jeffrey D. Horbar, M.D., and colleagues from the University of Vermont: Among infants delivered with the top of the head coming first, risk of brain hemorrhage was twice as high if gestational age was 30 weeks or less. Among infants delivered breech, transverse or compound, risk was two or three times higher if the duration of labor was six hours or more.

— *American Journal of Disease of Children*
Vol. 137, No. 7, pgs. 678-681

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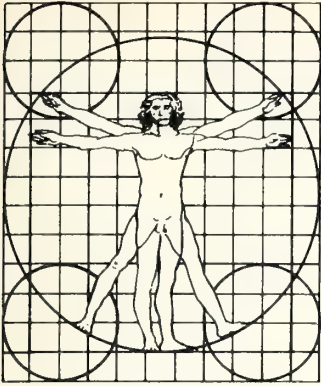
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CLINICAL & SCIENTIFIC

DIABETIC RETINOPATHY

Thomas J. Mehelas, M.D.
Carol R. Kollarits, M.D.

Diabetic retinopathy is the most common cause of blindness in adults in the United States today. Preservation of good vision in the diabetic patient requires that the physicians caring for the diabetic patient's medical problems examine the patient's eyes with the direct ophthalmoscope at every routine office visit. When diabetic retinopathy is discovered, the patient should be referred for complete ophthalmologic examination and treatment.

IN THE UNITED STATES there are approximately 4 million diagnosed and 2 million undiagnosed diabetics.¹ Diabetic retinopathy (DR) is the most common cause of blindness in the middle-aged population (ages 30 to 64).²

Statistics

The Framingham Eye Study, in which 2,631 people, 52 to 85 years of age, were examined, demonstrated that 2.9% of all patients in this age group were legally blind (visual acuity less than 20/200 with spectacle correction in the better eye).³ Fifteen percent of blindness was attributable to each of the following: diabetic retinopathy, cataracts, glaucoma, macular degeneration and amblyopia. The incidence of diabetic retinopathy increases with the duration of the disease. There is a 50% incidence in patients with diabetes of ten years' duration, a 60% to 70% incidence in 15 years and a 90% incidence after 20 years.^{1,2}

Nonproliferative Diabetic Retinopathy (Intraretinal)

Background Diabetic Retinopathy (BDR).—By direct ophthalmoscopy, background diabetic retinopathy is characterized by retinal venular congestion and intraretinal microvascular abnormalities (IRMA).⁴ The latter consist of capillary microaneurysms (dot hemorrhages appearing greater in number on fluorescein angiography, capillary dropout (seen only by fluo-

rescein angiography) and shunting. Hard exudates are composed of histiocytes phagocytosing transudated serum and glial-neuronal breakdown products in the outer plexiform layer. Retinal microcystic edema is seen as a "wet" appearance of the retina. Both superficial (flame- or splinter-shaped) hemorrhages located in the nerve fiber layer and deep (blot) hemorrhages in the outer nuclear layer of the retina are seen, though the latter are more characteristic (Fig. 1).

In the proliferative stage, soft exudates (cotton wool spots) are present in addition to the previously mentioned findings. Soft exudates result from focal ischemic infarcts of the nerve fiber layer.⁵ In the absence of uncontrolled systemic hypertension, soft exudates signal impending proliferative diabetic retinopathy (Fig. 2).

Proliferative Diabetic Retinopathy (PDR, Extraretinal)

When capillary nonperfusion results in extensive retinal ischemia, neovascular tissue develops, possibly in response to vasoproliferative factors released by the ischemic retina.⁵ Proliferation occurs 75% of the time at the optic disc where the internal limiting membrane is absent (Fig. 3). The remaining neovascularization occurs at the border of perfused and nonperfused retina. Neovascular fronds attach to the posterior vitreous surface.

Fibrotic Stage.—With time, the neovascular fronds contract, causing vitreous hemorrhage (Fig. 4) and traction retinal detachment (Fig. 5).

Neovascular Glaucoma.—Contraction of the neovascular fronds may result in a posterior vitreous detachment. This may allow egress of vasoproliferative factor from the posterior segment into the anterior eye with resultant rubeosis iridis (neovascularization of the iris, Fig. 6) and neovascular glaucoma.⁵ Interestingly, juvenile-onset diabetics develop rubeosis only after extensive proliferative retinopathy and posterior vitreous detachment. In contrast, adult-onset diabetics may develop rubeosis with little if any retinal neovascular proliferation. This is explained by the higher incidence of spontaneous posterior vitreous detachment and vitreous syneresis (degeneration) in the older age group. Lensectomy (cataract extraction) in conjunction with pars plana vitrectomy also is associated with a higher incidence of neovascular glaucoma. Presumably, this too is due to the loss of the vitreous and lenticular barriers to the anterior flow of vasoproliferative factor.⁶

Loss of Vision - Causes and Treatments

Background and Preproliferative Retinopathy.—In nonproliferative retinopathy, macular edema or exudates (circinate retinopathy) or hemorrhages may cause visual loss.⁷ These are manifestations of two diabetic vascular changes. One is the loss of the endothelial tight junctions (blood-retinal barrier breakdown). The second is the thickening of capillary basement

From the Division of Ophthalmology, Department of Surgery, Medical College of Ohio, Toledo, Ohio.
Dr. Mehelas, Toledo, Chief Senior Resident in Ophthalmology, Medical College of Ohio.
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Submitted January 6, 1982.

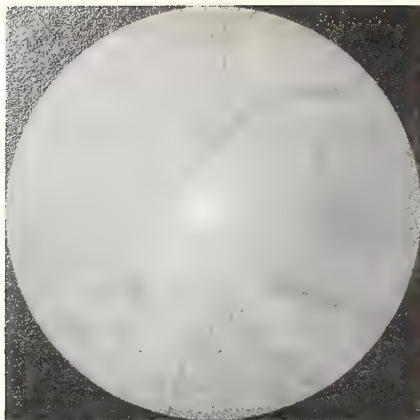


Fig. 1A

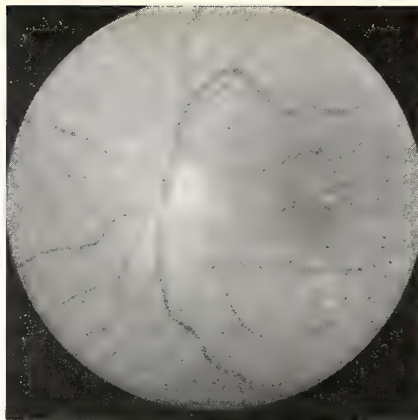


Fig. 1B

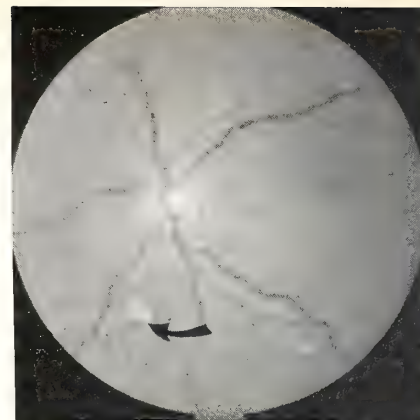


Fig. 2

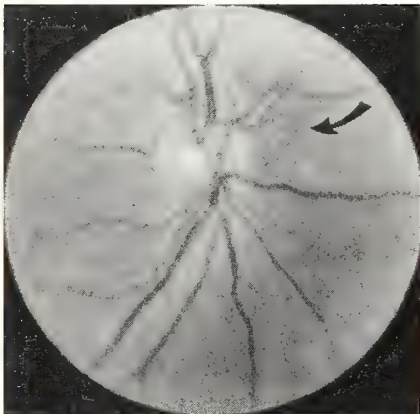


Fig. 3

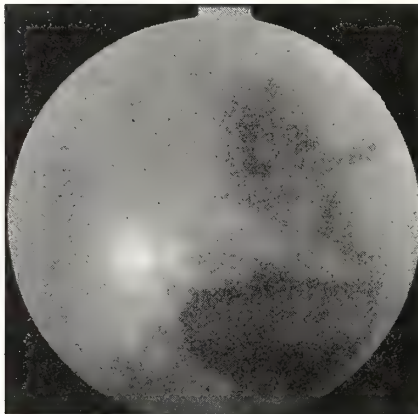


Fig. 4

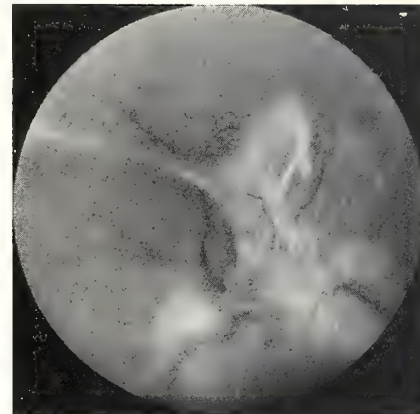


Fig. 5

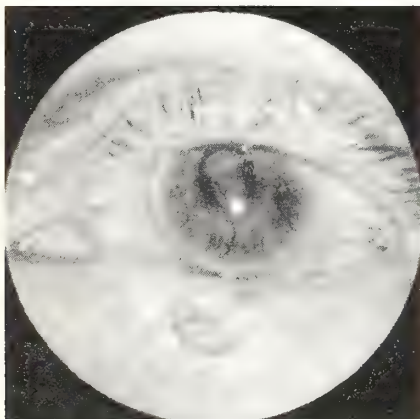


Fig. 6

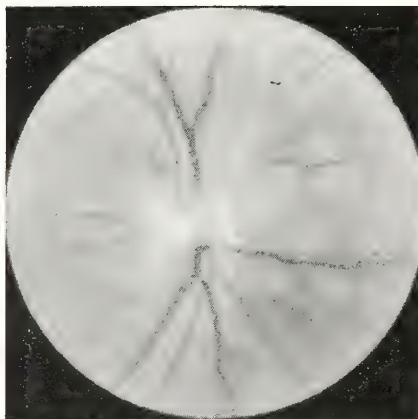


Fig. 7

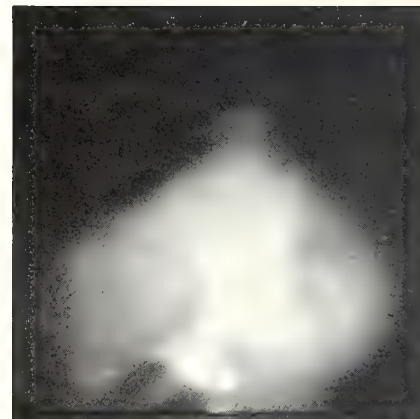


Fig. 8

LEGENDS FOR FIGURES

- Fig. 1a. Background diabetic retinopathy. Venous dilation and blot hemorrhages are present.
- Fig. 1b. Background diabetic retinopathy. Hard exudates predominate.
- Fig. 2. Preproliferative diabetic retinopathy. Soft exudates or cotton wool spots (arrow) indicate retinal ischemia and may precede the development of neovascularization.
- Fig. 3. Proliferative diabetic retinopathy. A neovascular frond (arrow) grows superior-nasally from the optic disc.
- Fig. 4. Vitreous hemorrhage. Neovascular tissue may bleed, causing preretinal or total vitreous hemorrhage. The preretinal hemorrhage is confined between the retina and vitreous. It appears to have a flat top because the red cells settle below, leaving serum above. Blood diffusing into the vitreous blurs the view of the disc and retina.
- Fig. 5. Contraction of neovascular fronds causes a limited traction retinal detachment superior-nasal to the optic disc.
- Fig. 6. Rubeosis iridis. New blood vessels on the iris surface may be accompanied by neovascular glaucoma. This eye also has dense cataract and history of traction retinal detachment.
- Fig. 7. Laser therapy. Following laser pan retinal ablation, neovascularization regresses (same eye as Fig. 3).
- Fig. 8. Removal of long-standing vitreous hemorrhage by pars plana vitrectomy. A vitrectomy instrument is shown excising decohered blood (white) and exposing the underlying retina.

Table

1. Diabetic retinopathy is the most common cause of blindness in the middle-aged U.S. population.
2. The incidence of retinopathy increases with the duration of the disease.

Duration	Incidence
10 years	50%
15 years	60%-70%
20 years	90%

3. Nonproliferative retinopathy

- a. Background — retinal venular congestion, intraretinal microvascular abnormalities (dot and blot hemorrhages) and hard exudates.

Preproliferative — above plus soft exudates (cotton wood spots).

- b. Loss of vision — macular edema, hemorrhages and exudates.
- c. Therapy — diabetic control, focal photocoagulation, ASA?

4. Proliferative retinopathy

- a. Neovascular fronds.
- b. Loss of vision — vitreous hemorrhage, retinal detachment, and neovascular glaucoma.
- c. Therapy — laser pan retinal ablation, vitrectomy, scleral buckling, laser goniophotocoagulation, and filtering procedures.
- d. 50% of the untreated will be legally blind within 5 years.

membranes.⁵ The enzyme glucosyltransferase is reversibly increased in the poorly controlled diabetic. This enzyme accelerates incorporation of glucose into hydroxylysine linked units of capillary basement membranes.⁴ Treatment at this stage is directed mainly at optimal diabetic control.

In addition to changes in the blood vessels, diabetics may have microvascular occlusions caused by changes in their blood. Characteristically, the diabetic's blood has a greater number of red blood cells, increased platelet adhesiveness and diminished fibrinolytic activity. Low dose (325mg/day) aspirin diminishes production of thromboxane A₂, a potent platelet aggregator and vasoconstrictor. However, the effect of aspirin in high doses is nullified by inhibition of endothelial prostacyclin, the most potent endogenous platelet deaggregator known. Unfortunately, the efficiency of low dose aspirin has not been conclusively proven.⁵

Focal laser photocoagulation may improve vision by "drying" paramacular exudates and hemorrhages.

Proliferative Retinopathy.—Vitreous hemorrhage and retinal detachment are the most common causes of permanent visual loss.⁸ Early laser pan retinal ablation (before the fibrotic stage) is the mainstay of therapy (Fig. 7). Laser treatment can cause involution of the vascular but not the fibrotic component of the fronds. If there is significant fibrosis or vitreoretinal traction, laser photocoagulation can stimulate further contraction with resulting hemorrhage and retinal detachment. Without laser treatment, 50% of eyes with proliferative diabetic retinopathy will be legally blind within five years.⁹ If hemorrhage has occurred prior to examination, laser treatment may not be possible until the hemorrhage has spontaneously cleared.

If vitreous hemorrhage does not clear within six months, pars plana vitrectomy may restore vision in many eyes (Fig. 8). Traction retinal detachment only occasionally can be helped by vitrectomy and scleral buckling procedures.

Neovascular Glaucoma.—Neovascular glaucoma develops in 5% of all diabetics and in 40% to 60% of those diabetics with proliferative diabetic retinopathy who have not been treated with laser pan retinal ablation.⁸ Neovascular glaucoma is best treated early by preventing or reversing early ischemic retinopathy with laser pan retinal ablation. It also can be treated with goniophotocoagulation (laser treatment of the neovascularization covering the anterior chamber aqueous drainage channels) if the angle is not closed by synechia. Unfortunately, medical management and standard surgical procedures such

as trabeculectomy have poor success rates.

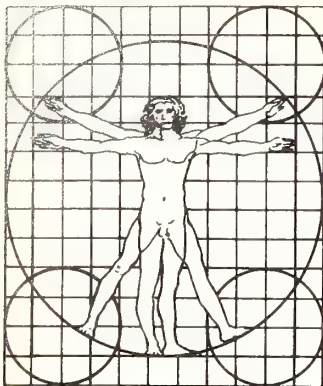
Argon laser pan retinal ablation may diminish vasoproliferative factor by either destroying ischemic retina or by thinning the retina sufficiently to allow the choriocapillaris to nourish the inner retina. If done early, the result is regression of retinal neovascular tufts and rubeosis iridis.⁹ Cryocoagulation also has been used. It is especially advantageous in the face of a dense vitreous hemorrhage in which the hemorrhage would absorb most of the laser energy.¹⁰

Summary

Early detection of diabetic retinopathy and referral for laser therapy can prevent most blindness caused by diabetic retinopathy and neovascular glaucoma. Yearly ophthalmoscopic examination should be done by the primary physician. When diabetic retinopathy is discovered, the patient should be referred to an ophthalmologist.

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CLINICAL & SCIENTIFIC

ROUTINE REALTIME ULTRASOUND IN A PRIVATE OBSTETRIC OFFICE

William E. Schamadan, M.D.

These observations are based on 15,000 realtime ultrasound scans, 4,500 patients, and five years' experience using this procedure in a private obstetric office. Of 202 nulliparous patients with a breech presentation at 32 weeks, 42 converted to cephalic at term. Of those 42 patients, 30 still required Cesarean delivery. For parous patients, 27 of 49 breeches converted, and all 27 delivered vaginally. Fetal sex was predicted for 1,021 patients with a 98.5% accuracy. Twenty major anomalies were recognized. This permitted earlier medical intervention and more adequate emotional support.

ROUTINE REALTIME ULTRASOUND SCANNING is a helpful, practical, enjoyable office procedure. Our six-man ob-gyn group began to do routine scans of obstetric patients in the office about six years ago. The data presented here are from our last five years' experience, and include almost 15,000 scans on 4,500 patients.

We started in 1976 with the 39th realtime ultrasound unit produced by ADR Ultrasound of Arizona. This unit has been regularly updated by ADR, and the capability of our present scanner (Model 2130) is vastly improved over that of our first unit. In 1976, there were very few ultrasound technologists for hire, so we started with an X-ray technologist who was interested in learning about ultrasound. She since has been certified as a Registered Diagnostic Medical Sonographer, and is a vital part of our operation. Our office now is used to train other personnel and test new ultrasound equipment.

Method

Obstetric patients have at least one routine scan at 20 to 22 weeks gestation and another at 32 weeks. We invite other family members to be present for this examination. The data in this paper are limited to breech presentation, sex determination, and fetal anomalies.

Breech Presentation

There were 202 nulliparous patients with a breech presentation at 32 weeks' gestation. In 42 patients, spontaneous conversion to a cephalic presentation occurred before the onset of labor. Of those 42 patients who converted, however, 30 still required delivery by Cesarean for lack of progress in labor.

Dr. Schamadan, Mansfield, Medical Staff, Mansfield General Hospital.
Submitted March 22, 1982.

There were 49 parous patients who had a breech presentation at 32 weeks. Spontaneous conversion to cephalic occurred in 27 patients, all of whom delivered vaginally. Of the 22 patients who started labor with a breech presentation, nine delivered vaginally and 13 required Cesarean delivery.

The incidence of breech presentation at 32 weeks for these 4,500 patients was 5.6%. The incidence of breech presentation at term was 4%, which is the usually reported incidence. Our Cesarean section rate has paralleled the national increase rate, and for 1980 was almost 15%.

Fetal Sex Determination

Since July 1980, we have attempted to determine fetal sex from the 32-week scan. Such a determination is possible 75% of the time. Scans of 1,360 patients permitted 1,021 sex determinations. There were 600 males predicted, with six incorrect. 421 females were predicted, with nine incorrect. The overall accuracy (1,006/1,021) was 98.5%. Most of the errors occurred early in the study, however, and our accuracy for the past six months approaches 99.8%.

About 20% of the patients did not want to know the sex of the child. Women who already had several children of the same sex seldom wanted to know.

Fetal Anomalies

The 20 major anomalies identified during this study period are listed in the table. Most of these were found at the 20-week scan, but some were found earlier because symptoms indicated a diagnostic scan earlier than routine. Two major anomalies were not identified. One diaphragmatic hernia was not recognized at the 20-week scan, and the patient delivered before the 32-week scan. One myelomeningocele was unrecognized.

The medical management of each of these problems could be a report in itself, but the author will comment only on the emotional aspects of care.

Several years ago our group realized patients needed more help in dealing with their grief than we were able to provide. As a beginning, a grief seminar was held, focusing on the loss of the wished-for child. Interested physicians, pastors, nurses office personnel, and social agency personnel were invited to attend. The response was overwhelming. We had obviously opened the floodgates of previously repressed emotions. From that tentative start, our present program developed. Now there are in-service updates about grief awareness and grief management for nursery, post-partum, and labor room per-

sonnel. Our office staff (physicians included) are exposed to the same information. We have added the services of a psychologist who has had special training in grief counseling. He counsels our patients and our personnel.

When an ultrasound scan identifies a major anomaly, or confirms an intrauterine death, we now can intervene earlier and more appropriately. Our intervention can be directed toward both the medical and emotional crises this family unit now faces. We believe having the opportunity to intervene earlier makes it easier to work through all the problems which are created.

Cost

A cost analysis for the first nine months of 1981 showed an ultrasound cost of \$18 per obstetric patient. The analysis includes technologist's salary, film, gel, equipment maintenance and updates, etc., but does not include the original cost of the unit purchased six years ago.

Joy

In the introduction to this article, ultrasound is described as an enjoyable office procedure. The husbands willingly take off from work to share this experience with their wives — the unrestrained excitement as couples see the reality of their pregnancy — the sudden spontaneous tears of joy when they hear a heartbeat. These are such positive experiences that the

word "enjoy" seems hardly adequate to describe them.

Conclusion

Realtime ultrasound as a routine office procedure is practical, helpful, and truly enjoyable.

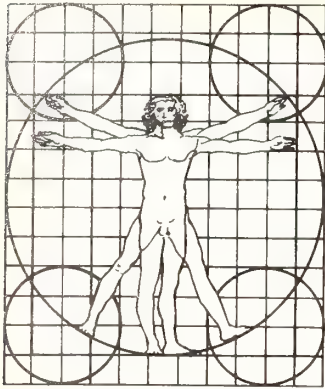
Major anomalies found by routine realtime ultrasound scanning of 4,500 obstetric patients.

Anencephaly	7
Hydrocephaly	1
Diaphragmatic Hernia	1
Gastroschisis	3
Polycystic Kidney	1
Pelvic Kidney with Hydronephrosis	1
Hydatidiform Mole	4
Conjoined Twins	1
Congenital Heart	1



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CLINICAL & SCIENTIFIC

THE ROLE OF PROPHYLACTIC REGIONAL NODE DISSECTION IN THE TREATMENT OF STAGE I MELANOMA: A REVIEW

Bradley C. Hiner, M.D.
John Peter Minton, M.D.

Malignant melanoma has long been considered one of the more aggressive and least amenable to treatment of all human malignancies. It accounts for 1% to 3% of cancers, and is the leading cause of death from all diseases arising in the skin. As with all cancers, the approach to malignant melanoma has undergone much change in recent years. At the forefront of debate has been the role of prophylactic regional node dissection in the treatment of Stage I melanoma. A review of the literature indicates that an aggressive surgical approach enhances survival in a subset of this disease.

MALIGNANT MELANOMA HAS LONG been considered one of the more aggressive and least amenable to treatment of all human malignancies. It accounts for 1% to 3% of cancers, and is the leading cause of death from all diseases arising in the skin.¹ The therapeutic approach to malignant melanoma has undergone much change as it has in all other cancers in recent years. At the forefront of debate in the past decade has been the role of prophylactic regional lymph node dissection in patients with Stage I cutaneous melanoma. We reviewed the pertinent literature in an effort to understand the two schools of thought in this controversy.

Before addressing the subject of regional lymph node management, it is important to consider the different methods of classifying melanoma. Specific variables have decided influence on the prognosis and treatment of this heterogeneous disease. Before 1967, malignant melanoma was considered a single morphologic entity with a uniformly poor prognosis. In that year, Clark, et al,² described a system classifying melanomas into nodular, superficial spreading, and lentigo maligna types. They demonstrated that the nodular type was the most malignant and the lentigo maligna type the least malignant. In addition, they defined five levels of invasion and found that the survival rate was inversely related to level of invasion. These levels are:

Level 1 — Intraepidermal melanocytic atypism (not considered as melanoma, recognized for research purposes only).

Level 2 — Tumor invading but not filling the papillary der-

mis layer, without extension to the reticular layer.

Level 3 — Tumor filling and expanding the papillary dermis layer but not invading the reticular dermis layer.

Level 4 — Tumor invading the reticular layer of the dermis.

Level 5 — Tumor invading the subcutaneous fat.

Subsequent investigation showed that melanoma that has not extended beyond level 2 usually causes death within five years in fewer than 5% of patients. However, nodular melanomas usually have extended to level 3 when first recognized and result in death within five years in nearly 45% of patients.³ As important as Clark's contribution was, there were serious problems with this approach. The distinction between an advanced lesion of one level and an early lesion of the next often was subjective. One study even showed that agreement among pathologists could be achieved only after consultation with Dr. Clark.⁴

In 1970, Breslow⁵ demonstrated that tumor thickness alone is a reliable measure for prognosis in cutaneous melanoma, thus providing an objective and easily reproducible method of tumor evaluation. He showed that all patients with lesions less than 0.76 mm thick were free of recurrence at five-plus years, while groups with thicker lesions had significantly higher recurrence rates at five-plus years: the 0.76 to 1.50 mm group had a 30% rate of recurrence; the 1.51 to 2.25 mm group had a 25% rate; 2.26 to 3.00 mm had a 70% rate; and those with lesions greater than 3.00 mm thick had a rate of recurrence or metastasis of 75%.

For the first time, Clark's and Breslow's classifications gave the physician the means to distinguish malignant melanoma into different categories of prognoses. From that point on, the debate over the surgical treatment for the different groups has raged. We examine first the evidence against routine prophylactic lymphadenectomy, and then look at evidence in favor of that approach.

Evidence Against Routine Lymph Node Dissection

Several questions concerning surgical morbidity and alteration of immune function have been raised by researchers who question lymphadenectomy. Causes of morbidity associated with lymph node dissection have varied from infection (20% in one series),⁶ to skin edge necrosis (30% to 40% after groin dissection according to Rosenberg),⁷ to extremity lymphedema after groin dissection (20% to 30% in one series,⁸ up to 60% in another).⁹ It also has been argued that the regional lymph

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nodes are an important immunologic defense, and their removal may have a detrimental effect on the host-tumor relationship.¹⁰ There also may be a mechanical alteration in lymph flow after lymphadenectomy so that cells become trapped "in transit" between the primary lesion and the regional nodes. This may provide a favorable environment for survival of residual tumor cells.

Far more important than these considerations is the contention that lesion resection plus prophylactic dissection has no advantage over wide resection alone on survival rates or incidence of recurrence. Conrad,¹¹ in 1972, compared the results of wide resection versus lymphadenectomy in 640 cases and found no significant differences in survival between the two groups. Other researchers¹² stated that if lymph nodes were removed as soon as significant lymphadenopathy was detected, prophylactic dissection was unnecessary. In the early 1960s, Cade¹³ found no statistical difference between the 69% five-year survival of patients who underwent initial node dissection and the 65% survival of those who had no initial dissection. The major problem with these studies was that they did not use either Clark's or Breslow's classifications, and so lacked a uniform staging system. In 1977, the World Health Organization (WHO)¹⁴ published results of a seven-year trial wherein therapy was prospectively randomized to excision of primary melanoma and immediate regional node dissection, or to excision of primary melanoma and regional node dissection on the appearance of metastases. Their analysis showed no difference in survival between the two groups of patients, irrespective of sex, site of origin of tumor, maximum diameter of primary tumor, or Clark's level, or Breslow's thickness. This last point is most important, and their data are shown in the table. They concluded that, "Elective lymph node dissection in malignant melanoma of the limb does not improve the prognosis and is not recommended when patients can be followed at intervals of three months."

The WHO group's findings subsequently were confirmed in a five-year Mayo Clinic study,¹⁵ in which patients were prospectively randomized to no lymphadenectomy, to delayed (three months) lymphadenectomy, and to immediate lymphadenectomy. They summarized their findings: "...none of these regimens differed significantly from the others in its effect on length of survival or interval to metastasis."

Evidence in Favor of Prophylactic Node Dissection

In 1907, W. Sampson Handley¹⁶ delivered to the Royal College of Surgeons of England a lecture entitled, "The Pathology of Melanotic Growths in Relation to Their Operative Treatment," in which he stated that, "The removal of the nearest chain of lymphatic glands, whether palpably enlarged or not, should never be omitted; for it may be taken as a matter of certainty in a great majority of cases they are infected." He continues that there is, "...an imperative need for removal of the lymphatic glands as a part of the first operation. Permeation of the lymphatic plexus of the deep fascia soon takes place around the infected glands, just as it occurs around the primary tumour. The excision of the glands must therefore be carried out on exactly the same principles as the excision of the primary tumour — that is to say, a large circular area of the surrounding deep fascia must be exposed, dissected up from its circumference towards the infected glands, and removed in one piece with them."

Dr. Handley's suspicion about local metastasis was borne out when studies showed that approximately 25% of all patients with Stage I (localized) melanoma have metastatic disease in nonpalpable regional lymph nodes.^{17,18} These data merely supported what surgical oncologists had thought for

years; clinically normal nodes may contain malignant cells which, if not removed, might adversely affect survival. In the late 1950s and early to mid-1960s came reports confirming this viewpoint. Gumport, et al,¹⁹ in 1959, reported five-year survival rates of 52% for patients with negative nodes by pathologic examination, 36% for patients with microscopically positive nodes, and a 13% five-year survival rate for patients who underwent delayed therapeutic node dissection. Southwick²⁰ found that patients who underwent prophylactic lymphadenectomy had a five-year survival of 80%, while survival was 33% for a group initially observed and later subjected to therapeutic dissection if necessary. Others^{12,21} reported similar figures. The major problem with these studies, of course, is the lack of a uniform staging system. In 1967 Clark stated that prognosis in malignant melanoma, independent of treatment, is inversely related to the level of invasion. Breslow²² in 1975 expanded on his earlier (1970) thesis that tumor thickness is a better measure of prognosis than level of invasion. In addition, he stated that prophylactic lymph node dissection doubled the rate of survival for patients with lesions greater than 1.50 mm thick, but had no effect on those with thinner lesions. These observations were supported by the work of other investigators,^{23,24} and there has since been "...almost general agreement that an elective lymph node dissection is no longer necessary for early Clark-Breslow lesions. The controversy still to be resolved ... is with advanced lesions."²⁵

The controversy was fueled by the findings in the WHO report and in the Mayo Clinic study which, as noted, showed no advantage in survival rates in the prophylactic dissection versus therapeutic dissection groups. Criticism of the report by Veronesi, et al, has centered around their concluding statement, "...since the proportion of positive nodes ranged from 20% to 25%, the wait and see policy avoids unnecessary post-operative complications in three-fourths of the patients for whom the dissection would result in negative nodes." The problem here was that this study had used a figure (25% node involvement) that was based on **all** patients with Stage I melanoma. As Goldsmith points out, histologically positive nodes can be expected to occur in 40% to 75% of patients with advanced Clark-Breslow lesions. For this group the percentage undergoing an "unnecessary" surgical procedure would be only 25%. It also should be noted that the WHO report itself showed an advantage in survival of 78.5% for the excision plus lymphadenectomy group to 69.7% for the excision only group in those patients with Breslow measurements of 1.5 to 4.5 mm.

The other major study against node dissection¹⁵ has been criticized for the similar reasons, that results are biased by inclusion of patients with low grade Clark-Breslow lesions. Fully two-thirds of the Mayo study's patients had lesions less than 1.5 mm thick. Almost one-third of the patients had melanoma less than 0.75 mm thick; of the 110 patients who had elective node dissection, only seven had histologic evidence of disease. This 6% incidence of metastatic disease in clinically negative nodes runs counter to the generally accepted rate of 25%, and underlines the "thinness" of melanoma in that study.

In 1979, Balch, et al,²⁶ published a multifactorial analysis of prognostic factors in Stage I melanoma. Using Cox's regression model to compare eleven parameters, they found two pathologic factors (tumor thickness and ulceration) and two clinical factors (initial surgical treatment and anatomic location) that were the dominant prognostic variables. Concerning the surgical approach, they found that two subgroups of clinical Stage I melanoma patients did not benefit from elective lymphadenectomy: those with lesions less than 0.76 mm thick, and those with lesions greater than 4.0 mm thick. Those patients with melanoma thickness of 1.5 to 3.99 mm had a 78% eight-year survival with wide excision plus node dissection,

while none survived more than eight years if a melanoma of the same thickness was only widely excised.

The important point Balch made is the need to examine intermediate and thick melanomas as separate groups. He even stated that when their data were analyzed in the same fashion used in the study by Sim, et al, (patients with lesions greater than 1.5 mm thick lumped in one group), no significant benefit of elective lymphadenectomy was apparent. But when the same data set was rearranged, those with melanoma of 1.51 to 3.99 mm thick had a statistically significant benefit with elective lymphadenectomy.

Conclusions

The debate over the efficacy of routine regional lymph node dissection in Stage I melanoma is sure to continue. This appears to be a classic "lumpers" versus "splitters" confrontation. Over the years, malignant melanoma was lumped into one diagnostic category, in retrospect making the data accumulated prior to the 1970s, before Clark's, and especially Breslow's work, practically obsolete. In the mid-1970s reports were published (specifically Veronesi, et al, and Sim, et al) which seemed to show that elective node dissection had no effect on survival rates. On closer inspection, however, these reports were marred mainly by errors of omission — they had not taken into account the biologic behaviors of subsets of melanoma by thickness. Balch's study²⁶ did this, and found an intermediate group (1.51 to 3.99 mm) for whom the addition of regional lymphadenectomy to wide excision had a profound impact on survival.

To reiterate the words of Dr. Handley in his 1970 lecture: "The removal of the regional lymphatic glands is not a very serious surgical procedure as an insurance policy against such a terrible disease."

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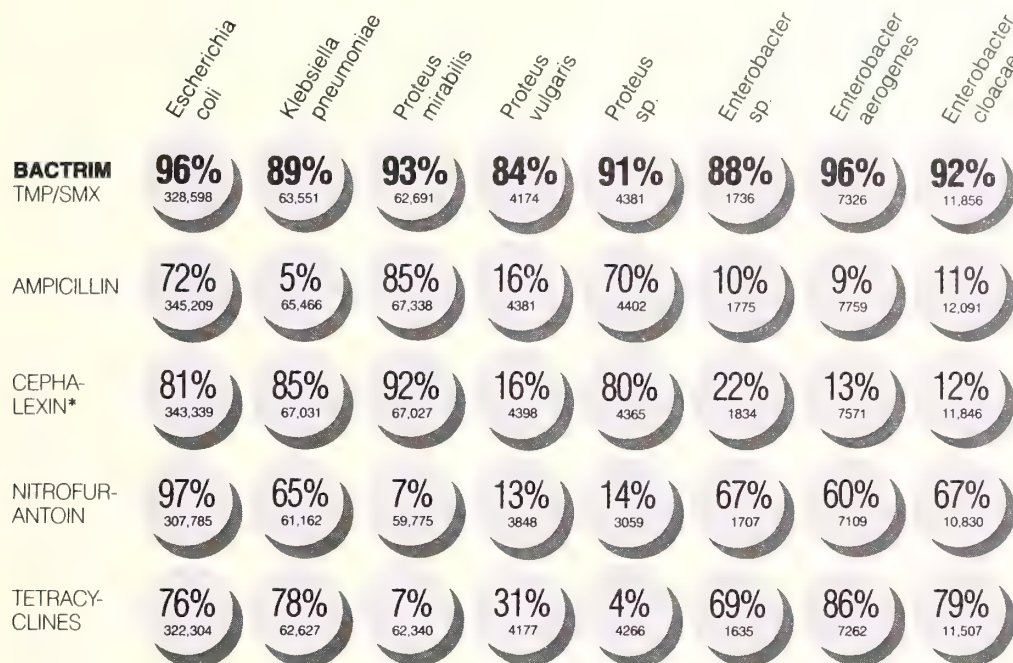
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Bactrim™ DS (trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsilopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. **Tablets**, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. **Pediatric Suspension**, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). **Suspension**, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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From the Editor's Desk

A Matter of Life and Death

Emergencies. It's medicine with a deadline, or, perhaps, more appropriately, a lifeline . . . the ultimate test of a physician's knowledge and skill.

Although Emergency Medicine is one of the profession's newest-recognized specialties, it is perhaps one of the oldest situations to exist in medicine. Matters of life and death have been around ever since humanity first drew breath, and they are not likely to disappear until humanity draws its last.

During these times, someone has to be there to throw death off guard, to take a life that's hovering between existence and extinction and nudge it back into that precious realm of the living. That's Emergency Medicine, and though it taxes the strength and perseverance of almost every physician who practices it, few would give up its rewards.

This issue of the *Journal* focuses on Emergency Medicine . . . its facets, its controversies, its state of the art. It's an area which few physicians — no matter what their specialty — can avoid entirely. After all, handling medical emergencies is simply part of a physician's job — but, sometimes, it helps to sit back and review just all that entails.

Special thanks go to William H. Gates, M.D., Chairman of the OSMA's Committee on Emergency and Disaster Medical Care, and to committee member Andrew DiBartolomeo, M.D., Akron, who not only gave their invaluable assistance and insight in planning the structure of this issue, but provided and solicited articles for it as well.

And, of course, a special thanks to the entire Emergency and Disaster Medical Care committee, who works

tirelessly to keep OSMA members updated and aware of a specialty that continues to change and grow, almost daily. **OSMA**

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Second Opinion

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

Death Education: A Must for Health Professionals

By William Price, M.D.

"The art of life is to pass gracefully from childhood to maturity, from youth to old age, and last as Montaigne said, 'To learn to die' ".

— Harry A. Savitz, M.D.
Journal of the American Geriatrics Society

Recently, an increasing number of books have been published on the subject of death and dying. Such activity suggests that present day society is becoming aware, if not preoccupied, with this universal and inevitable event. However, the quantitative number of books written are but one part of this total concern. Long held concepts are changing. We appear to be confronting the reality and inevitability of death through attempts to define what it means to "die a good death." Survivors are encouraged to confront rather than repress their feelings. This more realistic approach to death resembles in many ways the recent evolution in sex education. After many years of repressing human sexuality, there has evolved an awareness of its reality and importance in human life and experience. Society today is on the verge of experiencing the beginning of a similar awareness of the importance of dealing with death and dying.

The general trend for coping with death in our society has traditionally involved avoidance and control. Cultures can be characterized as death

defying, death accepting and death denying. Our own culture is in transition from death defying to death denying.¹ However, there is a small but growing movement toward death acceptance, initiated by such people as Dr. Elizabeth Kubler-Ross. As a health professional she has approached the problem by uniquely permitting the dying patient to be her teacher. As a result of such efforts, there is an increasing interest in death education. Nevertheless, the denial of death in our society is still more evident than is acceptance.

Today, physicians and nurses have mastered the management of the critical care patient and can effectively prolong life through the use of an arsenal of medical technology. However, they remain uncomfortable when dealing with the death event. Throughout their years of training, they are taught to view death as an enemy to be avoided at all costs, often at the expense of the patient's dignity. Death has been equated with failure instead of an inescapable event common to all mankind. This is

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Second Opinion

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unfortunate, since assisting the dying patient and family to accept the inevitability of death can be as rewarding as helping a sick patient recover. Many health professionals do not enter practice emotionally equipped to deal with the dying patient. Few medical or nursing schools provide death and dying as a significant structured course within the total curriculum. Thus the professional is left to cope with information garnered only from his own experience. During a formal course, personal conflicts arising from the fear of one's inevitable death can be effectively managed. The importance of the student's reflecting upon his or her own conception of death can not be overstated. Without any serious reflection on the part of the health professional, unresolved conflicts and fears may later interfere with effectively dealing with the dying patient. In addition, many health professionals contribute to their patient's anxiety because of inability to cope with their own discomfort about death.²

One of the most anxiety-provoking situations for the health professional is to face the problem of informing the patient that he or she is going to die. Many doctors and nurses know only too well the "lump in the throat" that occurs each time a patient or family member asks about death. The health professional can never be certain if, when, or how much to tell. A common myth that many health professionals hold is that the patient's lack of questions means that he/she is not interested in knowing. Sometimes patients are afraid to ask the doctor or may sense the doctor's uneasiness and thus delay asking. Regardless of the reason, it is surprising that the vast majority of patients want to know the truth. Yet, statistics indicate that between 69 and 90 percent of physicians, depending upon the study, continue to favor a conspiracy of silence regarding their fatally ill patients. Ironically, between 77 and 89 percent of the patients want to know the truth.³ The disparity between the patient's wishes and what the doctor feels is the right choice may in part be rooted in the medical school's lack of

education on death, dying, and the dying patient's needs. It certainly contributes significantly to the physician's discomfort with the subject of death. Some professionals may have never worked through their own conflicts concerning death which have arisen from personal experiences. Also, a doctor's refusal to tell a dying patient may have little to do with the doctor's thinking that the patient can not handle the news, but rather the doctor's inability to spend time communicating with the patient. As part of effective communication — it is not the information about death that creates a problem, but how it is carried out.

Traditionally, medical education has offered little help to the medical

"— It is not the information about death that creates a problem, but how it is carried out."

student encountering death for the first time.⁴ While death and dying have psychosocial dimensions, the process of medical education with its technical orientation tends to move the student toward an impersonal or purely biological view of death.⁵ Since 1975, this trend seems to be shifting as more and more medical schools offer death education programs within their curriculum. A team approach utilizing physicians and theologians in lecture discussion sessions has been instituted.⁶ Even though the number of programs has increased in the last five years, more needs to be done to insure that proper emphasis is placed upon such an important topic. Ten medical schools are still without any type of formal instruction on the dying patient and for many more the only exposure is that of a mini-lecture.⁶ It is inappropriate that a topic of such psychological and emotional importance be reduced to only a few hours of lecture. While it is promising

that more schools have chosen to initiate death education within their curriculum, these programs must be expanded and new approaches explored. One unique way of educating the student to effectively deal with death is that provided by Olin. He assigns first-year medical students to the family of dying patients much in the same manner that students are assigned to a mother who is about to give birth. In this way the human process of dying, the ending of life, can be taught in a similar setting as the human process of birth, the beginning of life.

Though our medical knowledge has increased and physicians have become successful in controlling disease and illnesses, our medical care system fails us when it interfaces with the dying patient. Often the health professional suffers along with the patient and the family. The list of problems is endless and frightening when one stops to reflect upon it. Nevertheless, creative solutions do exist which can be implemented. It is hoped that the medical school faculties will provide a continuum of death education which will include both didactic as well as important clinical experiences. **OSMA**

William Price, M.D., Youngstown, is an OSMA member and affiliated with the Western Psychiatric Institute and Clinic, University Hospitals, Pittsburgh, Pennsylvania.

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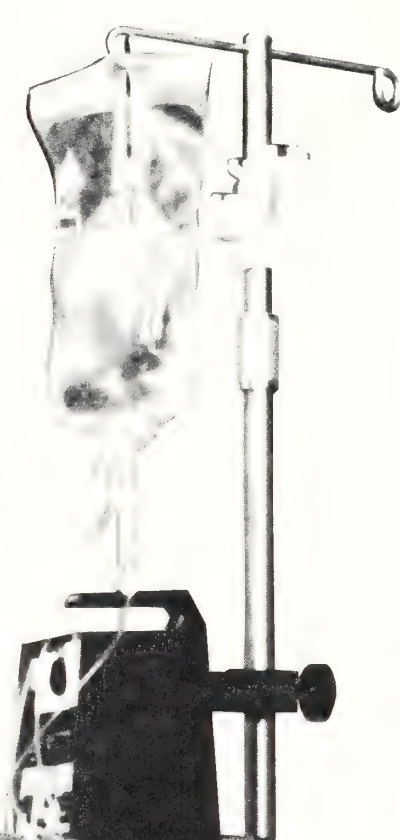
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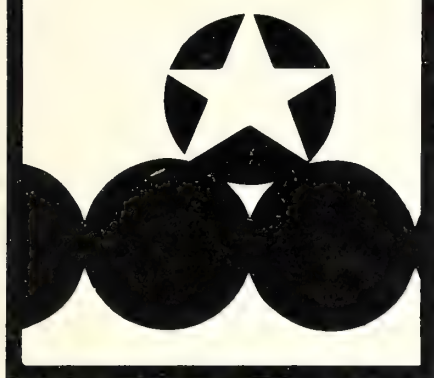
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SHERYL BUCKLEY, M.D., Cleveland, associate director of St. Luke's Hospital department of anesthesiology, is incoming president of the Women's Medical Society of Cleveland. Other officers include: **ANNE RASSIGA, M.D.**, president-elect, and **JANET BAY, M.D.**, secretary-treasurer.

The following Youngstown Hospital physicians received awards: **WILLIAM H. BUNN, M.D.**, the Golden Apple Award for outstanding service as professor and clinician of medicine for the department of internal medicine; **FRED W. KUNKEL, M.D.**, the Golden Apple Award as outstanding professor of the year for the department of internal medicine; **ERNEST EASON, M.D.**, resident of the year.

HENRY CRAMBLETT, M.D., Columbus, has been re-elected to a two-year term on the executive board of the National Board of Medical Examiners.

L.G. DALHEIM, M.D., Medina, was recently elected to the board of trustees of the American Lung Association of Northern Ohio.

ANDREW A. DETESCO, M.D., Youngstown, was recently honored as "Man of the Year" by the Italian Scholarship League of Youngstown.

DONALD K. EBERSOLD, M.D., Cincinnati, has been elected president of the Southwest Ohio Society of Family Physicians. Dr. Ebersold is associate professor of family medicine and medical director of the Family Practice Center at University of Cincinnati Medical Center.

ARTHUR T. EVANS, M.D., Cincinnati, received the 1983 Russell and Mary Hugh Scott Education Award at the 78th Annual Meeting of the American Urological Association. The award is given for long and dedicated service in urologic education.

ALEXANDER S. FISHER, M.D., and **WILLIAM BANFIELD, M.D.**, both of East Liverpool, were honored by the Columbiana County Medical Society for 50 years of service.

J. CHARLES GARVIN, M.D., Marion, was elected vice chief of staff at Community MedCenter Hospital.

MOSES HARTMAN, M.D., Cleveland, recently received the Golden Stethoscope Award for 50 years of service to the Mt. Sinai Medical Center. Dr. Hartman is a family physician.

WILLIAM D. HOLDEN, M.D., Cleveland, has been awarded the John C. Leonard Award from the Association for Hospital Medical Education for "long and distinguished identification with the promotion of the highest educational standards in community hospitals."

HAE WOHN JOHNG, M.D., has been appointed as the new medical director for Massillon State Hospital.

MILTON LAMBERT, M.D., Pomeroy, has been appointed to the National Board of Examiners for Orthopedic Surgeons.

KEITH LEHMAN, M.D., Wauseon, has been named to a three-year term on the board of trustees of the American Heart Association, Northwestern Ohio Chapter.

HARRY K. LYNN, M.D., Jefferson, was recently honored by the medical staff and board of trustees of the Ashtabula General Hospital for 50 years of medical practice.

LAWRENCE MARTIN, M.D., Cleveland, recently received the Julius E. Goodman Award from Mt. Sinai Medical Center. The award was established by the late Julius E. Goodman to be given annually to a physician who has made an outstanding contribution to the hospital.

LAWRENCE M. PASS, M.D., has been named chairman of the department of medicine at Youngstown Hospital Association.

S. THEODORE PINSKY, M.D., Toledo, is the recipient of the 1983 Ohio State Radiological Society's Distinguished Service Award. Dr. Pinsky also has served as an alternate delegate to the Ohio State Medical Association (OSMA) House of Delegates from Lucas County and was recently chosen to serve as the delegate to OSMA from the Ohio State Radiological Society.

WALTER A. REILING, JR., M.D., Good Samaritan Hospital and Health Center's chief of staff, has been elected to the Governing Council of the Section on Hospital Medical Staffs of the American Medical Association.

WILLIAM ROUSCH, M.D., Akron, was recently elected vice president of the Akron District Chapter of the American Heart Association during the association's annual meeting. Dr. Rousch is the director of Emergency Medical Service Activities for Akron City Hospital.

Recently elected at the Ohio Chapter, ACS, 28th Annual Meeting in Warren: President, **WILLIAM V. SHARP, M.D.**, F.A.C.S., Akron City Hospital; President-Elect, **STERLING W. OBENOUR, M.D.**, F.A.C.S., Zanesville; Treasurer, **JOHN PETER MINTON, M.D.**, Ph.D., F.A.C.S., Ohio State University, Columbus; Secretary, **RICHARD B. REILING, M.D.**, F.A.C.S., Dayton.

FRANK W. STROEBEL, M.D., Columbus, has been elected vice president of the Children's Hospital Medical staff and **THOMAS P. BEACH, M.D.**, was elected secretary/treasurer for 1983.

JON TIPTON, M.D., Marietta, has been named as one of three medical consultants to the United Mine Workers of America Health and Retirement Funds.

CREIGHTON WRIGHT, M.D., Cincinnati, has been appointed medical director of the newly developed division of Peripheral Vascular Surgery for the Jewish Hospital of Cincinnati.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Carol Wright Mullinax**

Women physicians see fewer patients but spend more time with them

Who is more likely to choose a woman physician? People under age 25 and other women, according to a report just published by the National Center for Health Statistics.

In a study of office practice patterns by family physicians and general practitioners, patients under age 25 accounted for 46% of visits to female doctors and only 29% of visits to male doctors.

Conversely, patients 45 and older constituted 44% of visits to men and only 34% of visits to women physicians.

In addition, compared to male physicians, female physicians saw more women patients than men (71% of visits versus 60%); treated more new patients (25% versus 11%) and received more visits for reasons other than illness (25% versus 16%).

The study also found that while the average woman doctor saw fewer patients in her office per week than her male counterpart (73% versus 96%), she spent more time with each patient.

Heart Affairs



You've probably talked with your male patients about resuming sexual relations after a heart attack, but have you talked with your female patients? A report in a recent issue of *Archives of Internal Medicine* reveals that, like male patients, women heart attack survivors also fear that resuming sexual relations could bring pain, another heart attack or even death. About 300,000 women survive a heart attack each year.

A survey of 130 women aged 38 to 65 who had had a heart attack showed that the frequency of sexual relations remained unchanged in only one-fourth of the 84 women who had previously been sexually active. Half of the women decreased their sexual activity and one-fourth did not resume at all.

In addition to the previously cited reasons, the women studied also

expressed doubts about their attractiveness to their partners and concern that the quality of the sexual relationships would suffer. Less than half of all the women studied, and less than two-thirds of the sexually active women, received any sexual counseling either before or after leaving the hospital.

Although conceding that at the present, counseling apparently has little effect in lessening the fear of resuming sexual activity for either sex, the researchers pointed out that this could be due to inadequate instructions that left patients' questions about risk unanswered. The researchers stressed the importance of taking a sexual history from all cardiac patients as well as the importance of sexual counseling for patients and their partners.

Impaired Physician Conference Set

The OSMA is sponsoring the "Third Ohio Conference on the Impaired Physician" on October 15-16, 1983, in Columbus.

Major emphasis will be directed to managing the stresses of medical education and newly-established practice, assisting the families of impaired physicians, and solving problems of rehabilitation, relicensure and re-entry to practice.

Also highlighting the two-day conference will be an audiovisual tribute to the late Perry R. Ayres, M.D., who served as chairman of the OSMA Physician Effectiveness Program from 1977 until his death in May 1983.

Keynote speaker will be Joseph R. Cruse, M.D., Director, Betty Ford Alcoholism Treatment Center, Rancho Mirage, California.

Among others participating on the conference faculty are Corwin R. Smith, M.D., Cincinnati, who replaced Dr. Ayres as chairman of the OSMA Physician Effectiveness Program; Pamela Jelly, R.N., specialist in family counseling, Mt. Carmel Family Practice Center, Columbus; William J. Kennedy, M.D. of Newark, and Deirdre O'Conner, M.D. of Toledo, both specialists in the treatment of physicians with substance abuse problems, and several specialists in confrontation techniques from the Physician Effectiveness Program. Oscar W. Clarke, M.D., President of the Ohio State Medical Board, and William Flynn, M.D., Director, Alcohol and Drug Clinic, Georgetown University Medical Center, Washington, D.C., also will be featured.

AIDS Clinic opens in Cleveland

In response to the demand for an evaluation center for potential victims of AIDS disease (Acquired Immunodeficiency Syndrome), physicians at University Hospitals of Cleveland recently opened a one-day-a-week, appointment-only clinic.

"At the newly opened AIDS Referral Center, patients will have the opportunity to be evaluated by a physician who is knowledgeable about the disease," noted Dr. Michael Lederman of the University Hospitals Department of Medicine and an AIDS researcher.

"Primarily, I believe, we will be providing a service for those people in the high risk groups for AIDS disease who are concerned or confused, especially in light of all the publicity AIDS has received in the media. These are people who are probably well, but worried," continued Dr. Lederman. "What we will be able to do is medically evaluate these people, give them sound advice about AIDS and, if appropriate, provide the necessary laboratory tests. It's important to note, however, that at present there is no laboratory test which is diagnostic of AIDS or even predictive of the risk of developing AIDS."

COUNTY SOCIETY ROSTER CHANGES

ALLEN: Roger D. Jenkins, M.D., President, 850 Bellefontaine Ave., Lima 45804.

BUTLER: George T. Manitsas, M.D., President, 1380 N.W. Washington Blvd., Hamilton 45013; James P. Baden, M.D., Secretary-Treasurer, 347 Park Ave., Hamilton 45013.

CLINTON: Janet Gick Matrka, M.D., Secretary-Treasurer, 222 W. Main St., Wilmington 45177.

CUYAHOGA: Richard B. Fratianne, M.D., President, 4996 Delevan Dr., Cleveland 44124; Daniel A. Deutschman, M.D., Secretary-Treasurer, 11201 Shaker Blvd., Cleveland 44104.

FRANKLIN: Ronald B. Berggren, M.D., President, 410 W. Tenth Ave., Columbus 43210; Daniel E. Lewis, M.D., Secretary-Treasurer, 111 S. Grant Ave., Columbus 43215.

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HENRY: Wilson J. Stough, M.D., President, 515 Avon Place, Napoleon 43545.

KNOX: Edward Yu, M.D., President, Knox Community Hospital, Coshocton Rd., Mt. Vernon 43050; James Wanken, M.D., Secretary-Treasurer, P.O. Box 591, Mt. Vernon 43050.

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TRUMBULL: Ms. Doris Dean, Executive Secretary, 280 N. Park Ave., Warren 44481, 216/394-4556.

VAN WERT: Robert C. Adams, M.D., President, 140 Fox Rd., P.O. Box 232, Van Wert 45891.

WASHINGTON: H.L. Krupadev, M.D., Secretary-Treasurer, 408 Third St., Marietta 45750.

Our new look . . .

Hope you like the new look! The *Ohio State Medical Journal* is now being printed on a better grade of paper. We think this coated stock will make the *Journal* more attractive and easier to read.

While looking through the *Journal*, take a few minutes to check out the new Medico Legal column. This column, which made its debut in the August issue, will appear monthly. It will be written by the OSMA's Department of Legal Services, D. Brent Mulgrew, Esq., Director, and Catherine C. Costello, Esq., Associate Director.

In a continuing effort to improve the *Journal* and keep it responsive to the needs of members, more changes are planned. Keep watching this space!

MISCELLANEA

New statistical data has confirmed a widely-held belief among physicians that ethnic groups have dramatically different mortality rates compared to whites.

According to the Journal of the U.S. Public Health Service, compared to whites, blacks have higher rates of heart disease because of the prevalence of hypertensive disease.

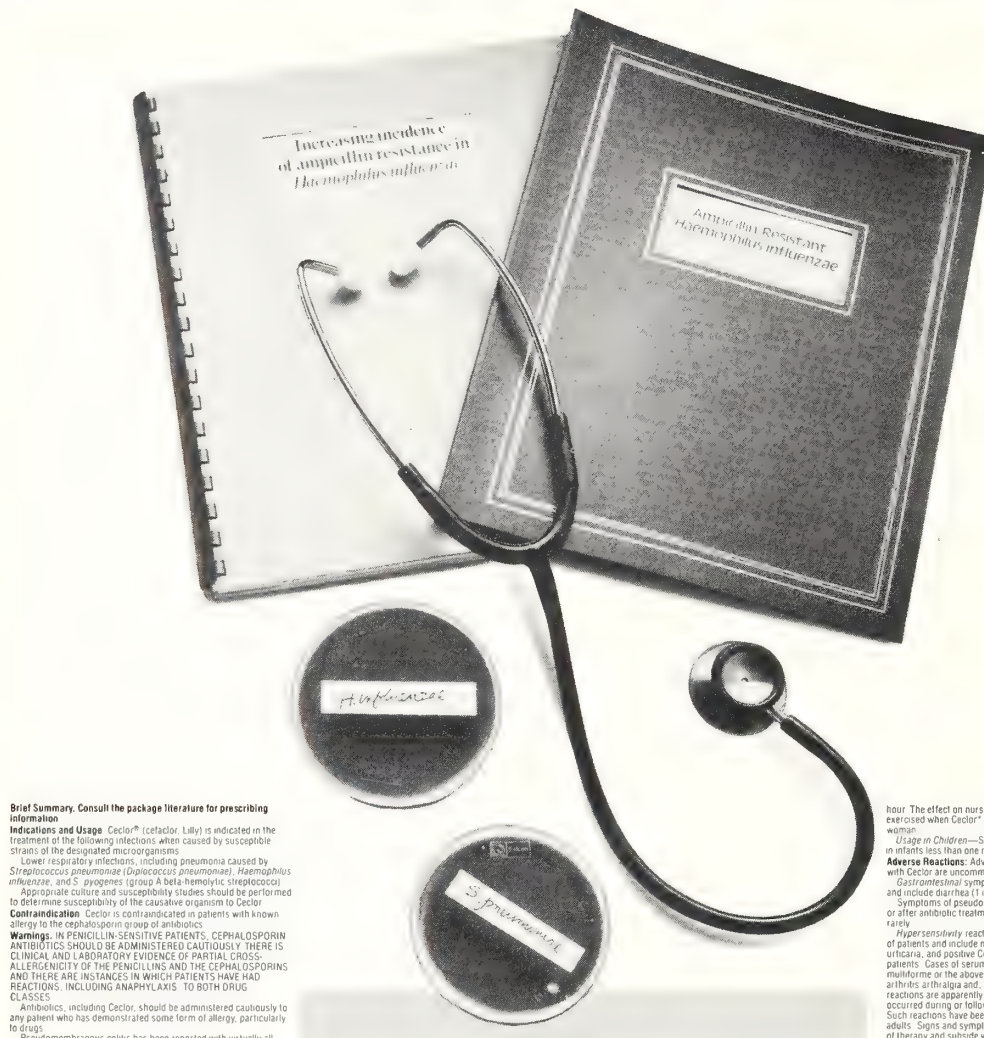
Native Americans show higher rates of auto accidents, because of greater travel distances, poor road conditions, unsafe vehicles and alcohol use. Mexican Americans have higher rates of diabetes and infectious parasitic diseases.

Health professions generally have fared well in the unemployment crunch, according to statistics released by the Health and Human Services Department's Bureau of Health Professions.

Physicians and dentists have the lowest unemployment rates among health professions — less than 1 percent. Registered nurses have an unemployment rate of 1.9 percent, followed by 2 percent for therapists and 2.4 percent for clinical laboratory technologists and technicians.

Only one category of health workers — nurses' aids, orderlies and attendants — had a higher employment rate in 1982 (10.1%) than all civilian workers (9.7%). Pharmacists also showed significant increases in the number of unemployed.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage Ceflor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (Diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceflor.

Contraindications Ceflor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceflor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics including macrolides, semisynthetic penicillins, and cephalosporins; therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriology studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Ceflor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceflor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceflor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceflor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinette® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceflor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceflor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.16, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceflor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceflor.⁷

Ceflor®

cefclor

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Ceflor® (cefclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceflor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceflor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceflor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46265. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

300035

The Ohio State Medical Journal

emergency

AT THE SCENE

By William Gates, M.D. and
Andrew DiBartolomeo, M.D.

There is no question that in trauma situations and acute myocardial infarction or life-threatening arrhythmias, the arrival of Emergency Medical Technicians (EMT) within four to eight minutes after the onset of these critical events has made a difference in mortality and morbidity rates. Nor is there any doubt that many other emergency health situations have been helped by well-trained EMT's able to respond to these needs at short notice.

Currently, however, physicians and EMT's have found themselves embroiled in controversies as they interact with patients — not only in

through specific treatments and procedures, allowable only under the supervision of a licensed physician who, by state law, certifies their standing orders. This applies to the EMT-Advanced IV Technician, and EMT-Paramedic who, by Ohio Code, are responsible for knowing specific information, becoming trained in specific procedures, and providing emergency medical assistance on a limited basis. Since these procedures and medical acts are functions that apply directly to the practice of medicine, these EMT's are given civil immunity, in order to serve the community without fear of being

the Ohio Board of Regents (again in direct compliance to the requirements of the Ohio Revised Code as passed by the legislature in 1976).

The problem then pertains to the development of nonphysician personnel, providing limited but highly trained medical skills and procedures. These personnel usually become very skilled and well practiced in defibrillation, use of cardiac arrhythmia drugs and treatment of shock due to trauma. Because of their limited role, however, they are bound by the Ohio Code not to go beyond its requirements or they lose their civil immunity.

On the other hand, physicians, who are licensed to practice medicine in the state, render a professional service which requires accountability. It is unlikely they will ever have civil immunity. However, many physicians, by reason of their specific area of medical knowledge, may or may not have highly practiced skills in CPR, recognition of ventricular defibrillation and other arrhythmias, use of anti-arrhythmic drugs, and provision of medical care for the patient in shock because of trauma.

The emergency medical services personnel are instructed by their supervisors (and their legal counsel) to provide their functions to the public only in specific ways. Yet frequently bystanders at the scene of an accident or health emergency will demand functions which the EMT's legally cannot perform or actions they are not qualified to carry out. Indeed, a physician present at the scene with much broader medical knowledge may

“ . . . Since these procedures and medical acts are functions that apply directly to the practice of medicine, these EMT's are given civil immunity

. . . On the other hand, physicians, who are licensed to practice medicine in the state, render a professional service which requires accountability. It is unlikely they will ever have civil immunity . . . ”

the doctor's office, but at nursing homes and on emergency street scenes as well. On one hand, EMT's are nonphysician personnel, highly trained in limited skills which are designed to counter medical conditions that kill and increase disability. They do this

culpable of practicing medicine without a license. In the community sense, these EMT's are allowed to function as an extension of the physician who signs the standing orders, under the supervision of the rules and regulations established by

ask or expect the EMT personnel to do medical functions that are expressly forbidden for them. The problem grows larger in those cases where the EMT personnel are going to transport the patient to the hospital and the physician at the scene does not or cannot accompany the patient to the hospital. What the physician determines that the patient needs for medical care prior to transport, and what the EMT's can do and must do may not match. This has led in some cases to EMT's ignoring physicians at the scene and in many cases has established disagreement between the physician and the EMT's during treatment at the scene.

It should be obvious that physicians are the proper group to provide medical supervision for these personnel (notwithstanding the need to recognize the qualifications and level of training of the individual physician involved). It also should be obvious that EMT's provide a natural extension of prehospital emergency care, and like the physician have the

patient's interest in mind. Both groups are after the same goal: less mortality and morbidity among citizens who sustain life-threatening health emergencies before they reach hospital care. The OSMA, working in conjunction with the Ohio Emergency Medical Services Advisory Council (OEMSAC), has established a dialogue with fire and rescue services and all others who provide emergency medical services to the citizens of Ohio. In fact, Ohio may be one of the first states to tackle this problem in such a forum. The Committee on Emergency Disaster and Medical Care invites your comments on these issues.

The 1982 House of Delegates of the OSMA requested the Committee to issue a report on the subject of medical direction of EMT's from physicians at prehospital settings for emergency medical care. The House received an interim report in 1983 and after thorough review, the Committee will forward its recommendations to the Council of the OSMA along with a full report to the House when

completed. In conjunction with OEMSAC, guidelines for the interaction of physicians and EMT's in prehospital care can be established, thus clarifying their respective roles and enhancing the medical care of the patient. **OSMA**

William Gates, M.D., Cincinnati, is Chairman of OSMA's Committee on Emergency and Disaster Medical Care and is President of the Cincinnati Academy of Medicine.

Andrew DiBartolomeo, M.D., Akron, is Chairman of the Government Affairs Committee for the National College and the Governor's Advisory Council in EMS affairs for the State of Ohio. He is also a member of OSMA's Committee on Emergency and Disaster Medical Care.

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Gradual Release LIPO-NICIN[®]/300 mg.

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Nicotinic Acid	300 mg.
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Thiamine HCL (B-1)	25 mg.
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Pyridoxine HCL (B-6)	10 mg.

in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN[®] 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Immediate Release

LIPO-NICIN[®]/250 mg.

Each yellow tablet contains:

Nicotinic Acid	250 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

LIPO-NICIN[®]/100 mg.

Each blue tablet contains:

Nicotinic Acid	100 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Beyond the Oxygen Tank

By Andrew DiBartolomeo, M.D.

The history of Emergency Medical Services in the State of Ohio seems endless but, suffice it to say, the system has gradually and positively developed since the days of the fire engine and a tank of oxygen.

Today, almost the entire state is served and covered by an Emergency Medical Services system. In addition, significant development has occurred in terms of transport, communication, equipment and education.

It is important to appreciate the influences upon prehospital care because such knowledge makes clear how progress has occurred. The major influences upon prehospital care have come from the consumer, government, the medical community, and the public and private prehospital providers. The intensity of these influences has molded prehospital care into the kind of systems we have within the local communities throughout Ohio.

The Role of the Consumer

The role of the consumer of

prehospital care cannot be discounted. It is the consumer who really determines the kind of prehospital system that his community will supply. Consumers determine and provide the economic support for a system and also provide the major source of critical evaluation. Because of consumer input and choice, a variety of systems exist throughout Ohio. It is left to the consumers within a local subdivision to generate the dollars necessary to support their EMS involvement. Certain variables such as geography and population sometimes make the choices limited, but still, the choice is made by the consumer.

It is important to understand that an informed consumer group should have the data necessary to make an

intelligent decision relative to the type, degree and cost of its EMS system. Once the system is operational, consumers share in the responsibility of making sure that the system satisfies their needs, remains cost effective and represents the quality they desire. Unquestionably, consumers are an important parameter in the development and maintenance of an EMS system. Since the EMS is a "mom and apple pie issue," the politician running for office often masks the important decisions that need to be made by the consumer. It is important that informed consumers unmask the "mom and apple pie" politician so that they are able to make a clear decision as to the kind of EMS system they wish to develop.

The Role of Government

The second group which influences EMS, both fortunately and unfortunately, is government. The role of the federal government in EMS was intense but short-lived. The real involvement of the federal government began with the passage of the National Highway Traffic Safety Act (NHTSA) in 1966. Unquestionably, this piece of legislation provided some funding for equipment and education within Ohio. Also, in 1966, the National Academy of Science in association with the American Medical Association published an important report entitled: *Accidental Death and Disability: The Neglected Disease of Modern Society*. This report highlighted deficiencies in our approach to the trauma patient and had a significant impact in the development of EMS throughout the United States. Significant interest in prehospital care continued by the federal government through the 1960s and into the early 1970s. This culminated in the enactment, in 1973, of the Emergency Medical Services System Act which was to provide assistance for the development of comprehensive emergency medical services systems throughout the country and thus improve the quality of patient care by reducing morbidity and mortality.

The federal regional approach to EMS was all but abandoned in 1981 when those dollars earmarked for EMS systems in Ohio (1.2 million)

were lumped into the Preventative Health Care Block Grant Program administered by the Department of Health of the State of Ohio. About 300,000 were used to fund EMS projects last year. Although the federal government has upgraded its involvement in disaster planning, its involvement in other areas of Emergency Medical Services has all but ceased.

Where the federal government involvement in EMS was costly, intense and short-lived, the involvement of state government has been more methodical, less money oriented, and more lasting. EMS has not, like in other states, become its own agency within state government. In Ohio, EMS functions are spread throughout various state agencies including the Department of Health, Board of Regents, Department of

Where the federal government involvement in EMS was costly, intense and short-lived, the involvement of state government has been more methodical and lasting.

Education, Highway Safety and the Disaster Services Agency.

It is clear that the major success story in Ohio EMS has occurred in the area of education. EMT-A (Basic Prehospital Provider) education is the responsibility of the Department of Education. This program began officially in 1958 and is presently administered by the Trade and Industrial Services (T&I) of the Division of Vocational Education of the Department of Education. The course is 90 hours in length including training in vital signs, in-hospital practical training, clinical experience

and driver education. To be certified a candidate must pass a written and practical examination upon successful completion of the course. Every three years an EMT-A must take 20-36 hours of refresher training and must be actively functioning as an EMT-A to be recertified. Currently there are 30,000 certified EMT-A's throughout the state forming the basis for our EMS services.

In addition to the education and certification of the EMT-A prehospital provider two other categories of prehospital personnel exist within the state. The Board of Regents is responsible for the education and certification of the advanced EMT-A's and paramedics. Upon successful completion of an accredited program of study, the individual is certified in the state. These individuals are required to maintain a certain amount of continuing education and must recertify every three years. At this time there are 4,800 paramedics and 4,500 Advanced EMT-A's throughout the state.

In addition to the educational and certification responsibilities of the Department of Education and the Board of Regents, the Ohio Department of Health (ODH) has played a significant role in the development of Ohio's EMS system. It was largely ODH which interacted with the various regional systems to gain federal funding for those programs. Through the support and federal funding, several regions in the State of Ohio have developed systems which are still functioning with some success. Most notably the programs in Toledo, Dayton and Wooster-Canton still function in a regional manner with a significant track record for efficiency and stability.

The Department of Highway Safety and Disaster Service Agency also have played an important role in EMS delivery throughout the state. The Highway Safety Department has been instrumental in obtaining funds for the purchase of vehicles and communication equipment.

In 1976, House Bill 832 was passed. This bill addressed many of the present operational aspects of EMS throughout the state. It created the

Ohio Emergency Medical Service Advisory Council (OEMSAC) to oversee and coordinate EMS throughout the state in addition to advising the governor and general assembly in EMS matters.

The Role of the Physician

The third group which has participated in the development of EMS has been the medical community. The catalyst which existed in the early days of EMS still remains as the catalyst today, namely, the physicians who work with the local squads providing educational support and medical direction. Without the support of these individual physicians and the general physician community, there could be no effective EMS in Ohio.

In addition to the local physician involvement, various organizations of physicians throughout the State are interested and vocal in relation to EMS. The Ohio Chapter of the American College of Emergency Physicians, The Ohio Chapter of the American Trauma Society, the Ohio Chapter of the American College of Surgeons and the Ohio State Medical Association, to name a few, are closely affiliated with the EMS movement in the State. Their input and direction are extremely valuable and absolutely necessary if prehospital care is to continue to improve.

The Role of the Prehospital Provider

The final link in the chain is the prehospital provider. This group is made up of thousands of dedicated men and women educated to a level of excellence to provide this vital service.

Unquestionably, the personnel who make up these life support squads are truly dedicated and selfless individuals whether they be volunteer or paid. The training and continuing education are expensive and difficult and the working conditions are never optimal in that they are called upon at all hours, into all types of environment and weather and expected to excel. Those basic techniques that we take for granted when performed in the controlled environment of our office, surgical suite or emergency department take on a different perspective when they necessitate being done with the

same efficiency in the middle of the night in a driving rain storm. However, the real problem for prehospital providers and their superiors is not the weather, the difficulty of their job or the hours. The real problem for EMS, as for so many things in this modern world, is economics.

Inflation has hurt EMS as well as the loss of a predictable tax base. The major reason the fire chiefs, city fathers, and private managers are upset is that they are caught in the economic fix of too few dollars to provide the quality EMS that local government and citizens say they must provide. It is truly through the ingenuity of the private and public EMS managers that EMS is surviving but the breaking point is at hand. There is no doubt that help is needed to insure that quality personnel and service are maintained.

The dilemma of the prehospital providers are numerous but revolve primarily around the economics of their situation. For the individual who works in the private sector, the pay is usually less than adequate, despite his educational background and his professional standing. The high cost of doing business and the relatively poor reimbursement for services for the private provider has worsened this situation.

The problems of the volunteer EMS provider are also based on economics. The cost of training in dollars and time, causes a significant amount of personnel hardship and thus, turnover for these squads. A large percentage of Ohio's EMS units are all or part volunteer and, in my experience, these volunteer squads represent some of the highest quality services in the state. Fortunately, the feeling of civic pride and token payments to these very professional volunteers has slowed the demise of these squads, but they continue to decrease in number. Their disappearance will represent a significant loss for EMS and Ohio citizens.

As stated earlier, the real big economic problem is confronted by the managers of these systems, whether public or private, paid or volunteer. As in all areas of health

care there are limited dollars available and through inflation the size of those dollars are shrinking. It is imperative that we recognize this situation and respond to it. We must be cognizant, as physicians, that our demands for quality in prehospital care must be also cost effective. We have to temper our demands for equipment, procedures, documentation, and education of the prehospital providers because *unneeded* sophistication and red tape are the factors which will ultimately bankrupt our good system in Ohio.

At the same time we must be certain that we maintain those stigmas which guarantee a quality system and be certain, no matter how strong the voices that are asking for relaxation of regulation change, that we not sacrifice our quality and principles in safe patient care.

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Andrew DiBartolomeo, M.D., Akron, is Chairman of the Government Affairs Committee for the National College and the Governor's Advisory Council in EMS affairs for the State of Ohio. He is also a member of OSMA's Committee on Emergency and Disaster Medical Care.



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emergency

Disaster Defined

By Andrew Bern, M.D.

Disasters have been part of history since humanity's earliest recollections, but what is meant by a disaster? Simply stated, a disaster is any event, either natural or man-made, which disrupts the normal functioning of a community, endangering the lives and property of its citizens and exceeding its usual ability to respond.

This response capability differs from community to community and has added to the confusion of what a disaster is. To a rural Emergency Medical Service with one advanced life squad, a school bus-car accident with 15 casualties might warrant the activation of their disaster plan and a call for mutual aid from surrounding areas. Given these same circumstances in a large metropolitan area, however, the capabilities of the local Emergency Medical Service might not be exceeded, no mutual aid would be required and a disaster would not exist.

Therefore, the ability of a community to respond to multiple casualties identifies the level of the medical disaster. Three levels of disaster have been established for identification purposes.

A Level I medical disaster signifies that a local emergency requiring mass casualty care exists. Local medical resources within one or more jurisdictions are available and adequate to provide for field (on-site) medical treatment and stabilization including triage. The patients will be transported to the appropriate local medical facility for further diagnosis and treatment.

A Level II medical disaster is a mass casualty emergency requiring regional support when the number of casualties and/or lack of local medical care facilities are such as to require regional or multi-county medical mutual aid.

Any mass casualty emergency which requires State or Federal support is classified as a Level III medical disaster. In this type of disaster, local, interjurisdictional and regional medical resource capabilities are exceeded and/or overwhelmed, and deficiencies in medical supplies and personnel are such as to require assistance from State and/or Federal agencies.

Disasters do not always affect a community in a uniform fashion. Select agencies or responders might be affected without involving the entire community's resources. For example, in an airplane crash with no survivors, the disaster impacts most intensely on the coroner, police, fire, the media, and appropriate agencies such as the Federal Aviation Administration. In this case, a medical emergency

requiring the utilization of Emergency Medical Responders is not required.

The term multiple casualty incident (MCI) helps to clarify the distinction between disasters which overwhelm a particular agency's ability to respond and those incidents involving the Emergency Medical System, its physicians, and nurses where multiple patient casualties are present.

Man-made or natural disasters are common occurrences. The American Red Cross reported their involvement in the United States during their 1982-1983 fiscal year in over 4,500 disasters, spending over 33.5 million dollars from their disaster service budget. Hazardous materials incidents are also commonly occurring. Over this last year, more than 6,300 incidents, or an average of 17

TABLE
**FEDERALLY (PRESIDENTIALLY)
DECLARED DISASTERS: 1963-1982***

1. March, 1964	— Floods: Central, Eastern, and Southern Ohio
2. April, 1964	— Tornadoes: Northwest and North Central Ohio
3. April, 1968	— Tornadoes, Storms, and Flooding: In eleven counties in Southwest and Central Ohio
4. May, 1968	— Flooding: Thirty counties in Central and Southern Ohio
5. July, 1972	— Storms and Flooding: Seven counties in Northeast Ohio
6. November, 1972	— Flooding: Counties bordering Lake Erie
7. April, 1973	— Flooding: Counties bordering Lake Erie
8. June, 1973	— Mudslides: Hamilton and Washington Counties
9. April, 1974	— Tornadoes and Storms: Fourteen counties in Mid-Central Ohio
10. May, 1974	— Flooding: Lucas, Ottawa and Sandusky Counties
11. July, 1974	— Flooding: Warren County
12. August, 1980	— Flooding: Guernsey, Belmont, Jefferson, Monroe and Muskingum Counties
13. June, 1981	— Tornado: Morrow County Flooding: Putnam, Wyandot, and Hancock Counties
14. March, 1982	— Flooding: Fulton, Lucas, Paulding, Wood, Williams, Defiance, and Henry Counties

*Source: Miami Valley Civil Defense/Disaster Service Authority

incidents per day, were reported. In the State of Ohio between 1963 through 1982, there have been 14 Federally (Presidentially) declared disasters (see Table).

Ohioans have demonstrated leadership in both disaster planning and management. On November 9, 1959, the Miami Valley Civil Defense/Disaster Services Authority was established in an agreement between Greene and Montgomery Counties. It remains today, the only independent Civil Defense/Disaster Service Authority in the country.

In 1963, the Disaster Research Center of the Ohio State University was established as the first center of its type in the country, and today it remains the largest. The

Dayton/Montgomery Health District began the development of a Hazardous Materials Response team in the 1970s which is now under the guidance of the Miami Valley Civil Defense/Disaster Services Authority.

In 1978, Governor Rhodes signed an Executive Order establishing the assignment of responsibilities under the most recent "Ohio Natural Disaster Plan." The Ohio Veterinary Association became the first Veterinary Association in the country to become incorporated into a state's plan. The Emergency Medical Services Advisory Council (to the Governor) published the "State of Ohio Communication Plan" in 1981 and the "State of Ohio Emergency Medical Services Disaster Plan" in 1982.

Disaster planning and management are demanding and challenging areas for physicians and Emergency Medical Responders. Certainly, there has been increased legislative and financial interest in improving our country's "disaster preparedness" since the late 1970s, and as Ohioans, we can be proud of our state's own leadership and accomplishments in this rapidly developing field.

Andrew Bern, M.D., Cincinnati, is Associate Director, Department of Emergency Services, Good Samaritan Hospital and Assistant Clinical Professor, Department of Emergency Medicine, Wright State University School of Medicine.

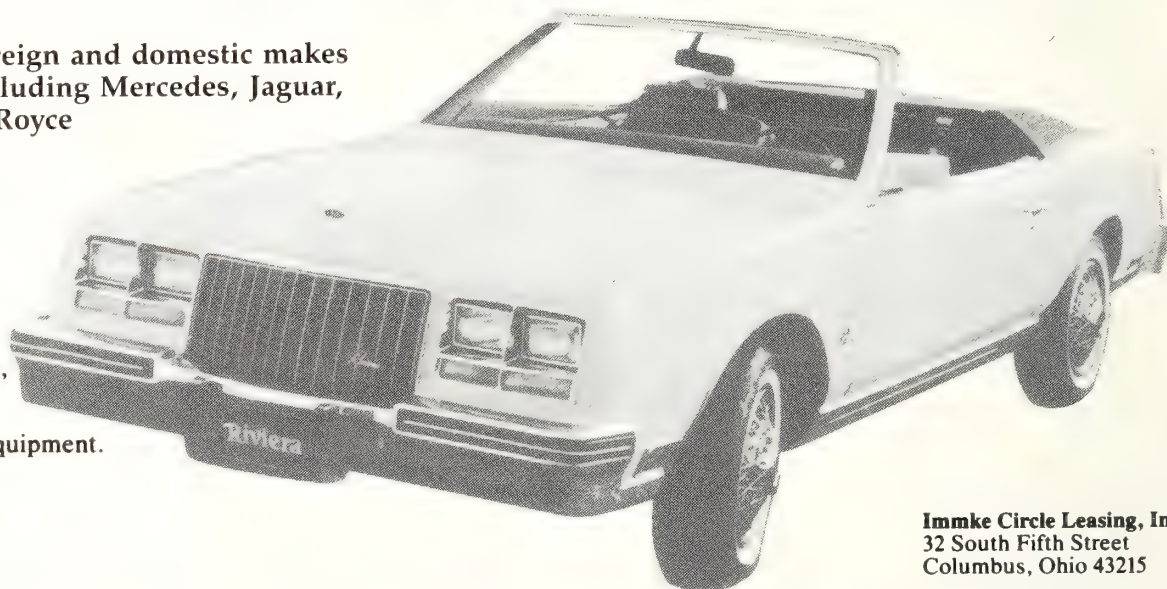
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Emergency Medicine Education

By Michael Saddleton, M.D.



While the early foundations of the specialty of emergency medicine and the American College of Emergency Physicians (ACEP) were being laid in Michigan in 1968, other interested physicians were laying down the graduate/residency training program. The first of these programs was that of the University of Cincinnati, which graduated its first resident in 1971. Other programs slowly followed throughout North America; these early programs tended to lean towards other specialties, especially medicine and surgery. Incidentally, the first

The manner in which this new branch of medicine specialized caused some teething problems which have since been resolved.

emergency medicine residency established in a community hospital was at Akron General Medical Center in 1975.

As ACEP further defined its role, so too was the educational course content and curriculum of emergency medicine residencies defined. The programs covered the medical and surgical fundamentals, and of course, the emergency aspects of all the other specialties. The manner in which this new branch of medicine specialized "horizontally" across the whole field of medicine, rather than concentrating in a somewhat narrower or "vertical" manner as do the other specialties,

caused some initial teething problems; these have been largely resolved.

More than 83 million patient encounters a year make emergency departments a portal of entry for many Americans into the health care system of the United States. This statistic demonstrates the need not only for the upgrading of in-hospital emergency services, but also for the involvement of the emergency physician in the arena of pre-hospital care, particularly in emergency medical systems (EMS).

The specialty was formalized as the twenty-third to be recognized by the American Board of Medical Specialties (ABMS) in 1979. At this time, the American Board of Emergency Medicine (ABEM) became prominent in the educational arena as the certifying body for emergency medicine. At this time, approximately 1,200 physicians have graduated from residency programs, and another 700 are in training. The 63 residencies are inundated with applications for positions, despite continuing minimal exposure of students to emergency medicine in the medical schools. Seven residency programs are currently endorsed in Ohio:

Akron City Hospital
Akron General Medical Center
Mt. Sinai Medical Center
(Cleveland)
OSU Hospital (Columbus)
St. Vincent Hospital (Toledo)
University of Cincinnati
Wright State University (Dayton)

Michael Saddleton, M.D. is president of the Ohio Chapter of the American College of Emergency Physicians (OACEP) and Associate (Clinic) Professor of Emergency Medicine at Akron City Hospital.

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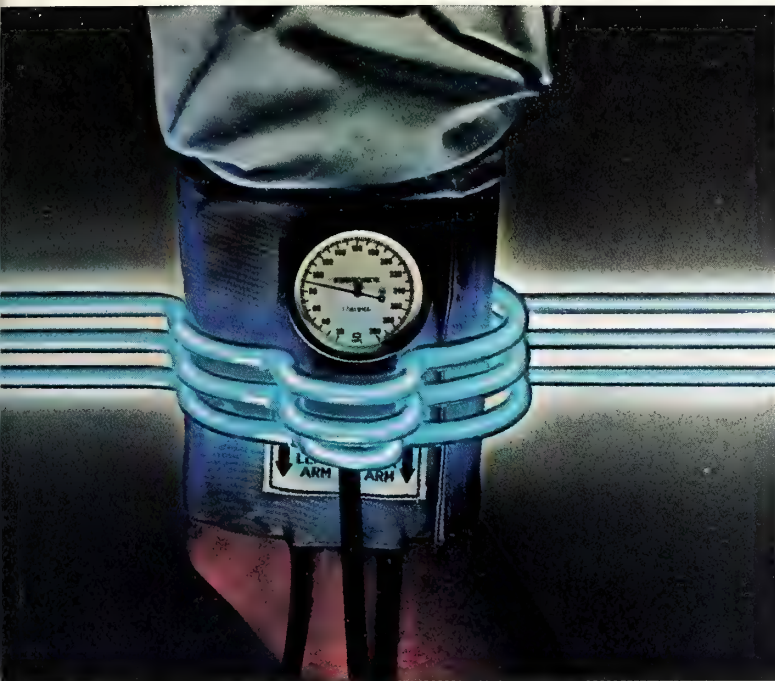
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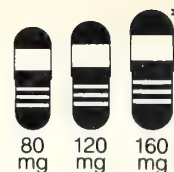
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(Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

Inderal LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

Inderal LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Inderal (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension, paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of Inderal LA capsules is a registered trademark of Ayerst Laboratories.

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Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

emergency

The Ohio Chapter of the American College of Emergency Physicians

By Michael Saddleton, M.D.

The emergency physician never knows what type of case will come into the emergency department. It could be the victim of an automobile or industrial accident, a patient suffering a cardiac arrest, or a child who has swallowed household detergent. The emergency physician could be faced with cases of rape or child abuse, or with alcoholics who no longer have control of their lives.

Emergency physicians must make rapid decisions on appropriate treatment, the need for hospitalization, and the type of consultation which may be needed. In addition, they must calm worried family members and approach the patient with the attitude of caring professionals.

The unique aspects of emergency care caused eight physicians to work for creation of a specialty of emergency medicine. In 1968, they organized the American College of Emergency Physicians with the goals of improving the quality of care provided in emergency departments and having the specialty recognized by the American Board of Medical Specialties (ABMS).

The College has since become the thirteenth largest medical specialty society with more than 11,000 members and approximately 800 of those members belonging to Ohio Chapter ACEP. In September, 1979, ABMS recognized emergency medicine as the twenty-third medical specialty.

Both the National and State organization are concerned with the political affairs of medicine in general and, in particular, with emergency medicine and emergency medical services in a continuing effort to assure quality patient care. We

endeavor, of course, to work with the staff and committees of the Ohio State Medical Association and other specialty societies on these matters whenever possible.

ACEP developed an examination to certify the skills and training of physicians in emergency medicine, which was first administered in early 1980 by the American Board of Emergency Medicine (ABEM). The certifying Board, now an independent organization, determines if candidates have received adequate preparation

and training, administers a comprehensive examination to evaluate candidates, and certifies physicians who satisfy the requirements for the specialty field.

A Residency Review Committee (RRC) for Emergency Medicine has been established under the auspices of the Accreditation Council on Graduate Medical Education (ACGME). This committee is responsible for recommending accreditation of emergency medicine residency

continued on page 765

STATE AGENCIES INVOLVED IN EMS

1. OHIO EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL (OEMSAC)

Membership:

Andrew DiBartolomeo, M.D.,
F.A.C.E.P., Chairman, Akron,
Ohio

Robert D'Annabelle, Vice Chairman,
Steubenville, Ohio

William Gates, M.D., Cincinnati,
Ohio

Lowell Joy, Lakeside, Ohio

Ted Howell, Dayton, Ohio

Jack Higgins, Youngstown, Ohio

Jack Liberator, Canton, Ohio

*Robert Counts, Troy, Ohio

*Eric Voth, Akron, Ohio

Wilbur Bills — Executive Coordinator
Address: 246 North High Street, Co-
lumbus, Ohio 43215

Phone: 614-462-8561

OEMSAC meets on the first Thursday
of the month at 10:00 a.m. at the
Beightler Armory, Worthington, Ohio

* Resigned August 31, 1983

2. OHIO DEPARTMENT OF HEALTH (ODH)

Bureau of Supportive Services
EMS Division

Thomas A. Gardner, M.D. — Bureau
Director

William Snouffer — Division Admin-
istrator

Address: Ohio Department of Health,
246 North High Street, Columbus,
Ohio 43215

Phone: 614-466-5410

3. OHIO STATE DEPARTMENT OF EDUCATION

Health Occupation Education

James Bartholomew, D.D.S. — State
Supervisor

Address: 65 South Front Street, Room
918, Columbus, Ohio 43215

Phone: 614-466-9447

4. OHIO BOARD OF REGENTS

John Zickafoose — Administrator

Address: 3600 State Office Tower, 30
East Broad Street 36th Floor, Co-
lumbus, Ohio 43215

Phone: 614-466-6000



St. Vincent Hospital's Life Flight helicopter has the capability to fly at 125 m.p.h. up to a distance of 130 miles from the helipad.

emergency

By land . . . or by air?

High hopes are attached to Emergency Medicine's latest innovation. But would it work in *your* area?

By Frank E. Foss, M.D.

The background . . .

The transport of critically ill and injured patients by air is a concept adapted from military experience by an ever increasing number of hospital-based helicopter services. Although the safety and efficiency of such services is well established, currently available adult air transport services can vary from an independent aviator offering "air taxi" transport to a highly sophisticated, hospital-based air transport team offering trauma care.¹

Four years ago, St. Vincent Hospital and Medical Center in Toledo, Ohio, in an attempt to improve its capability of providing specialized medical care to the ill and injured patients, implemented an emergency air medical service known as Life Flight.

Life Flight serves a 30 county area up to 130 miles away from the

hospital, since in this region, there are remote areas where ground ambulance service may not be considered the most appropriate emergency vehicle service.

The advantages . . .

The helicopter's arrival at the scene presents several advantages for the patient:

1. rapid access to advanced life support techniques,
2. emergency physician availability,
3. specially trained emergency nurses,
4. sophisticated communications,
5. continuation of advanced life support care throughout the transportation process, and
6. versatility of service.

Most authorities agree that there is a "golden hour" starting at the time of injury. As time elapses without

appropriate treatment, the patient's chances of survival diminish. Life Flight's intervention during this "golden hour" provides trauma care at a time when immediate care can have the most impact on the patient's future health.

In situations where a skull fracture has occurred through the middle meningeal artery, speed of treatment is critically important. The time lapse between injury and the operating table affects the patient's ability to regain his or her brain function. Death is most likely if any delay occurs. The best results occur with brain displacing injuries such as epidural hematomas, sub-dural hematomas, and displaced skull fractures, when the patient arrives at the tertiary care center within minutes.

For example, a nuclear power plant employee experienced a brain-

displacing injury. Life Flight was called and was able to transport the patient to the tertiary care center in Toledo within 30 minutes from take off from the helipad. Ground transportation would have taken at least an hour.

Traditional emergency medical service is excellent for many emergency runs; however, the nature of ambulance staffing and configuration influence the level of care provided. Terrain and road conditions also impact significantly at times. Although speed is not the most important ingredient in the helicopter's delivery of care, it is one important aspect of this service.

Patient comfort and minimization of further injury is another benefit of a program such as a Life Flight. A quick, gentle flight of short duration is less traumatic to the patient than a surface ride of an hour or longer. And the versatility of the helicopter, with its capability of lifting off vertically, makes it possible to reach isolated areas or the tight surroundings of an urban environment with special ease.

The staff . . .

The Life Flight crew consists of an experienced pilot, flight nurse and emergency medicine physician, all of whom are on duty around-the-clock. A flight mechanic is responsible for the helicopter's maintenance. It takes just four minutes for the crew to assemble and lift off for the scene of an accident or wherever the patient is waiting for treatment and transportation.

Emergency physicians and senior emergency residents, whose competency in advanced cardiac life support and advanced trauma life support has been proven, head Life Flight's medical crew. Both the physician's medical skills and communication skills are put to use. Once the patient is reached, the physician communicates medical facts to the receiving institution.

The Flight nurse's role is of great importance as a source of assistance and consultation. The experienced nurse is skilled in advanced cardiac life support and advanced trauma life support, as well as other pre-hospital

modalities including triage and emergency medical service communication.

Communications . . .

Communication is vital to good disaster planning and function. Communication with local police and fire departments, hospitals, and emergency medical services streamlines the care provided to the patient and provides the information to the receiving facility which often works to the patient's advantage.

While enroute to the scene, the physician and nurse are able to remain in contact with the emergency room with the use of air-to-ground communication systems, enabling the helicopter crew to have access to information they may need at the site.

Once Life Flight is airborne, the physician can communicate with the emergency department to orient them to the patient's condition, response to treatment while in the air, and what can be anticipated upon arrival of the patient in their emergency department. Too, the needed specialist is alerted, allowing him or her time to start for the hospital. In the meantime, the hospital emergency and other appropriate departments begin preparations for the patient. This advance preparation results in efficient patient care with minimal time being lost in communication of the patient's condition upon arrival at the hospital.

Upon arrival, the Life Flight physician and nurse begin the transfer of authority and responsibility with a consultation and examination of the patient. There are some situations in which the Life Flight physician will work with the emergency department physician to provide further treatment.²

Is it right for you? . . .

It would not be appropriate for most hospitals in the United States to consider offering an emergency air medical service such as Life Flight. Major medical facilities located in substantial metropolitan areas with a stable cadre of physician specialists who are available at all times are best



The emergency air medical service is able to transport two critically ill or injured patients. The flight physician and nurse have ready access to the patient. The helicopter is equipped as a mobile emergency department and this fact makes it possible for the flight medical team to treat any type of emergency case.

suited for an emergency air medical service. Several factors should be considered before such a service is instituted:

1. Local health system agency permission should be obtained.
2. The hospital's existing strengths should mesh with the emergency air medical service's goals. The hospital should also have a desire to improve the referral pattern. Operation of this service should respect any geographic restraints.
3. The service should be financially feasible and have a major impact on improving health services in the area.
4. The hospital should enjoy a reputation for superior medical care and/or should be designated as the trauma center for the area it plans to serve.
5. A comprehensive and ongoing public relations effort must be

started early and aimed specifically at potential users. Potential users are referring physicians, referring hospitals, rescue units, law enforcement agencies, and civil defense officials; not the general public.³

The Life Flight program is unique to the Toledo area, but the concept is not new in the United States. An emergency air service was initiated at St. Anthony Hospital Systems in Denver, Colorado, in October, 1972. This service was designed to use helicopters and fixed-wing aircraft in the transportation of seriously ill and critically injured patients. It was through this innovation that other areas began to realize the importance of air transportation to medical care.

The Denver program established itself from a personal and operations standpoint on the basis of its locale. The institution's primary point of view was the mountainous country west of the city. The peculiar needs of Denver dictated the type of emergency air medical service to be offered — a combination of flight nurses and helicopters.

In Houston, Texas, Hermann Hospital was addressing a different need and designed a program which utilizes registered nurses and surgical residents with the addition of pediatric residents for specialized missions such as neonatal transports.⁴

As each new program begins, the hospital's medical staff and administration must examine the mission of the hospital and must assess the needs of their community before establishing the emergency air medical service staffing procedures and its policies.

William T. Fitts, Jr., M.D., founder of the American Trauma Society, noted that "trauma, such as that suffered on the nation's highways, is the most ignored health problem in this country." More than 120,000 American lives, half of them in cars, are lost annually as the result of traumatic accidents, costing nearly 50 billion dollars. Another 380,000 persons receive permanent injuries, and 11 million more are injured, to some extent, by trauma.⁵

Life Flight is intended to be an extension of the emergency department. It is a prehospital care

service and an interhospital transfer and referral service. Whatever kind of cases are entrusted to the Life Flight crew, they recognize their responsibility for treatment beginning with the first call and the initiation of the first bit of planning relative to that particular case. **OSMA**

Frank E. Foss, M.D., Toledo, is medical director of Life Flight and Director of St. Vincent/Toledo Hospitals Emergency Medicine Residency Programs. Dr. Foss is also a member of the OSMA's Committee on Emergency and Disaster Medical Care.

References

1. Foss, Dr. Frank E., speech "Should Ambulances Fly?", 1979.
2. Foss, Dr. Frank E., position paper, 1979.
3. *Op cit.*, "Should Ambulances Fly?", p. 3.
4. *Ibid.*, p. 1.
5. *Op cit.*, position paper, p. 1.



The Life Flight pilots are military trained. The skill of these pilots and the specially-equipped helicopter make it possible for the team to fly in most weather conditions, excluding severe thunderstorms, fog, and heavy icing.



Once on the ground, the flight team begins their transfer of authority to the emergency department's staff. On occasion the flight physician will remain with the patient to assist the emergency department physician.

Easier claims

handling

Cutting down on forms and reducing time-consuming claims handling are important advantages of the new ADVANCE Plan agreement, now being introduced by Ohio Medical Indemnity Mutual Corp., the Blue Shield Plan headquartered in Worthington. The streamlined claims handling procedures designed into the program can reduce your administrative costs — and ours at OMIM as well. The agreement asks that

you accept as payment-in-full our UCR reimbursement for covered Basic services you perform. In return, as a cooperating ADVANCE Plan physician, you'll benefit from easier claims procedures, including automatic direct payment to you of Blue Shield Basic claims... reduced CRT terminal costs for use of our OPEN automated, paperless claims data entry system... and a direct toll-free line to an inquiry service in our Worthington offices for questions about procedures and claims. For full details, ask your Blue Shield Professional Relations area representative. Easier claims handling. It's one of the advances of the

ADVANCE PLAN

Good business theory,
put into practice



Blue Shield

Ohio Medical Indemnity Mutual Corp.

INTRODUCING
THE

ONE

TO COUNT ON

NEW

ONCE-DAILY

INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



THE ONE
TO COUNT ON
FOR THE EXPERIENCE
OF INDERAL—

**A unique controlled-release
formulation offers effective
24-hour beta blockade**

Regardless of pH or contents in the GI tract, INDERAL is diffused from small spheroids at a controlled and predictable rate.

**Providing clinical results
equivalent to tablets**

In controlled clinical studies, a single daily dose of INDERAL LA provided the same therapeutic response as equivalent doses of conventional INDERAL tablets. While there is little correlation between plasma levels and clinical effect in hypertension and angina, blood levels achieved with INDERAL LA are usually lower than those achieved with an equivalent mg dosage of conventional INDERAL due to differences in hepatic metabolism.

THE
ONE
TO COUNT ON

WITH ONCE-DAILY DOSAGE

In hypertension, angina,
and migraine

Smooth 24-hour control

Unsurpassed simplicity
and convenience

Single daily dosage for
enhanced patient compliance

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



80 mg



120 mg



160 mg

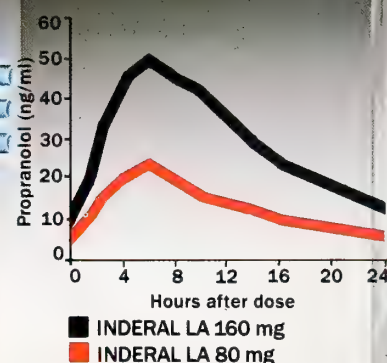
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Ayerst Laboratories.

NEW

ONCE-DAILY

INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

MEAN PLASMA LEVELS
ATTAINED WITH INDERAL LA
OVER 24 HOURS



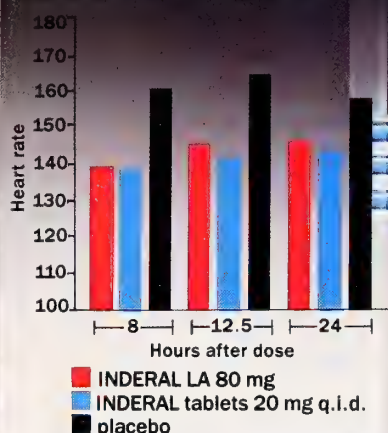
THE ONE
TO COUNT ON
FOR SMOOTH
PLASMA LEVELS—

Sustained plasma levels

In pharmacokinetic studies, blood levels with once-daily INDERAL LA were found to be adequate to maintain sustained clinical effect throughout 24 hours. The unique controlled-release formulation of INDERAL LA minimizes differences between peak and trough plasma concentrations.

THE ONE TO COUNT ON

EFFECT ON POST-EXERCISE HEART RATE OVER 24 HOURS*



AND 24-HOUR BETA BLOCKADE

Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose—with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg



120 mg



160 mg

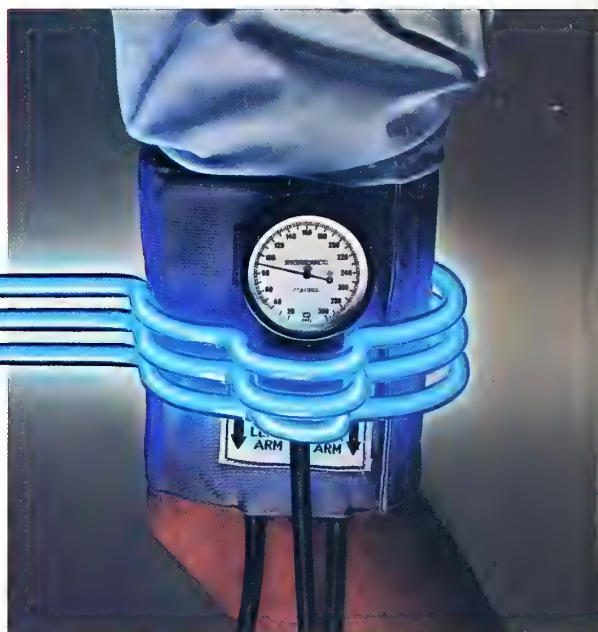
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*INDERAL LA vs. tablets: N.S. at all hours measured.

*INDERAL LA vs. placebo: $p < .05$ at all hours measured.

Please see last page for Brief Summary of Prescribing Information.

NEW
ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



**THE ONE
TO COUNT ON
FOR INITIAL
THERAPY IN HYPERTENSION**

Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

**Unsurpassed convenience
and simplicity**

Enhanced patient compliance



THE
ONE
TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of INDERAL

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



80 mg

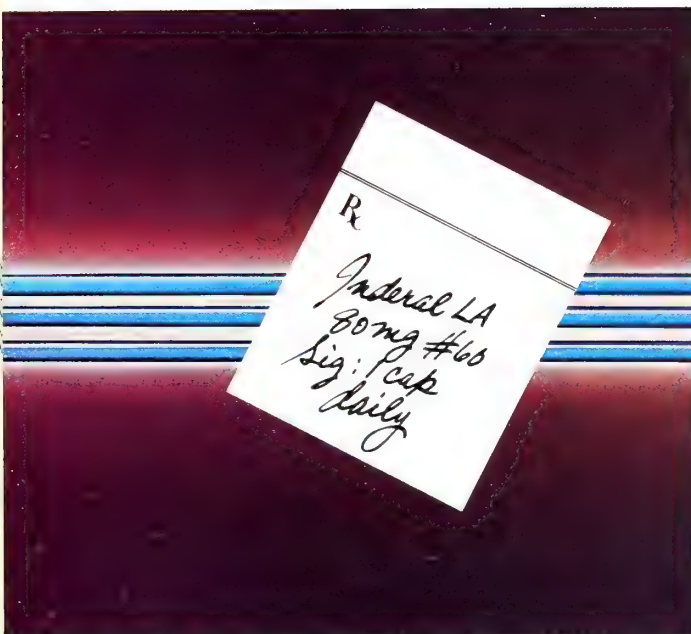


120 mg



160 mg

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THE
ONE
TO COUNT ON

**THE ONE TO
COUNT ON FOR
THE EXPERIENCE
OF INDERAL
NOW WITH ONCE-
DAILY DOSAGE**

In hypertension, angina, and
migraine— start with 80 mg
once daily

Smooth 24-hour control

Unsurpassed simplicity and
convenience

Enhanced patient compliance

Three strengths for prescribing
convenience

For arrhythmias, use
conventional INDERAL® tablets

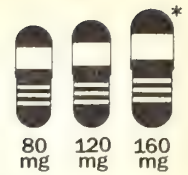
Ayerst®

AYERST LABORATORIES
New York, N.Y. 10017

Please see last page for Brief Summary of Prescribing Information.

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

ONCE-DAILY INDERAL[®] LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)
INDERAL[®] LA brand of propranolol hydrochloride

(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal LA is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal LA, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal LA has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal LA has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal LA also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilation activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal LA is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctiva reported for a beta blocker (prololol) have not been associated with propranolol.

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HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

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Freestanding Emergency Centers: An identity crisis not yet resolved

By Carol Wright Mullinax

There is a first-class identity crisis going on and it promises to be an interesting one. At issue are the new freestanding emergency centers (FECs) which are springing up all over the country. Are these centers mini-emergency rooms and therefore subject to the many rules and regulations governing hospital emergency rooms or are they merely a new type of physician's office and, as a result, allowed to operate relatively regulation-free? The answer is yes, depending upon whom you ask.

For the uninitiated, the premise of a FEC is very simple. The centers provide health care to walk-in clients on a 14-to-16 hour-a-day 7-days-a-week, 365 days-a-year basis. Most centers are staffed with at least one physician (usually board certified in either family medicine, emergency medicine or both) and a support staff. Some centers are private, investor-owned corporations (with a surprisingly large number of physician owners and investors) while others are operated by hospitals as free-standing units.

According to the National Association of Freestanding Emergency Centers, there are 1,000 FECs in operation in this country now with 4,500 predicted by the year 1990. The reason behind the proliferation of these centers, supporters say, is convenience. The centers offer all the advantages of an emergency room — nonappointment, after-hours care with none of the disadvantages — long waits and higher costs. As such, they add, FECs are perfectly suited for today's busy lifestyle.

Critics argue that as a cross between physician offices and hospital emergency rooms, FECs are a failure at both. They contend the centers offer neither the high technology care of an emergency room or the long-term continuous care of a physician's office — charging, in effect, that the centers "cheat" the public by offering only "episodic" care.

Privately, some physicians and hospital emergency departments worry that these centers will siphon their patients away.

The reason behind the proliferation of these centers, supporters say, is convenience.

Gary Meller, M.D., Akron, President and Medical Director of MEDAC, Inc., a corporation which funds and builds FECs, says that local physicians were worried about this when he opened his first center in Akron in January of this year. As an M.D. with a M.B.A. from Harvard, Dr. Meller currently has three centers in operation in Akron, two under construction in Cleveland with four more planned in that area, and is studying seven other midwestern sites.

Instead of seeing FECs, hospitals and private practitioners as adversaries in a battle for patients, Dr. Meller says, "We integrate our services with the other practitioners," pointing out that his centers refer patients who need specialized or continuing care to private practitioners and refer seriously ill patients to area hospitals.

He says his centers haven't taken patients away from anyone — hospital ERs or private practitioners.

As far as hospitals are concerned, a recently released report backs Dr. Meller up. In an article which appeared in the *Annals of Emergency Medicine* on the impact of FECs on hospital emergency room use, the authors concluded that the presence of one of these centers in an area does not seem to lead to a decline in the number of visits to nearby hospital emergency rooms. The reason for that, the authors suggest, is that the public may not perceive the FECs as a substitute for the Emergency Room but rather as a substitute for the private physician's office.

FEC supporters are quick to point out, however, that if physicians located near FECs notice a drop in their patient load, it could be attributable to a wide variety of other factors, including the proliferation of other types of health care delivery systems: HMO walk-in clinic, multi-specialty groups with expanded hours and hospital out-patient clinics.

The alternative forms of health care delivery have flourished, they say, because they are meeting an increased demand on the part of the public for more convenient health care. Dr.

Meller predicts that, in responding to that need, more physicians offices will come to resemble FECs.

But patients aren't the only ones who stand to benefit from the convenience of an FEC. Dr. Meller says that convenience also is an issue for physicians. The 20 physicians employed by MEDAC, Inc., are paid a good salary with benefits such as profit-sharing, and work reasonable hours. Dr. Meller says these physicians don't have to worry about the business side of medicine and thus have the freedom to practice "the kind of medicine they were trained for."

With convenience as the byword, it sounds as if there could be some type of FEC on every corner within the

In response to the public's need for convenient health care, more physicians' offices will come to resemble FEC's . . .

next five years. It is that fact that had many health care experts worried. Technically, it could have happened since FECs always have been considered physician's offices and, as such, exempt from Certificate of Need.

But a new 90-day emergency rule proposed by the Ohio Public Health Council and signed by the Governor may change all that. The emergency rule forces physicians, hospitals and corporations interested in establishing FECs to apply for Certificate of Need before they begin to build.

It is a temporary measure designed to give state officials and the new director of health, David Jackson, M.D., time to evaluate the "health" of health care in Ohio. When elected, Governor Richard Celeste vowed to make the state's health care delivery system more efficient and less costly. By the time the 90-day moratorium is over, the state legislature should have considered legislation designed to make good that promise. It remains to be seen if FECs will remain under Certificate of Need.

But Ohioans aren't the only ones pondering the fate of FECs. In June of this year, the AMA House of Delegates adopted "Guidelines for Freestanding Emergency Centers" which contained operating criteria addressing the hours of operation of the centers, staffing and medical direction, relationship to the Emergency Medical Services System and ancillary services and equipment.

The National Association of Freestanding Emergency Centers, of which Dr. Meller is a member, filed a complaint with the Federal Trade Commission charging that the criteria would "restrain trade" by impeding the growth of FECs and, as a result, deny the public cost effective health care.

What all of the controversy boils down to is this: Where do the FECs fit in the overall health care delivery system? Will they continue to operate as physician's offices virtually regulation-free or will FEC face increased regulation and standardization of care that hospital ERs face? While no one knows the answer to this question, one thing is clear. Increased pressure, both political

and medical, will make it very difficult for FECs to remain in the nebulous area between the two. **OSMA**

Carol Wright Mullinax is Associate Director, OSMA Department of Communications.

Ohio ACEP

continued

programs to the ACGME. Parent bodies of the RRC are ACEP, ABEM and the American Medical Association. Naturally, ACEP and Ohio ACEP are concerned with undergraduate, graduate and post graduate education in the discipline of emergency medicine. Ohio was the first state to organize an association for emergency medicine residents. The Emergency Medicine Residents of Ohio (EMRO) is a viable organization whose members are enthusiastic and active.

The Ohio Chapter of ACEP maintains an office at 1395 East Dublin Granville Road, Suite 401, Columbus, Ohio 43229, 614/846-0076. Please feel free to contact this office with questions you may have concerning emergency medicine. **OSMA**

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The Physician and Ohio Law

"The Physician and Ohio Law" is being introduced as a column in the **Journal** in response to the growing number of legal questions which are addressed to OSMA from the county societies and OSMA members. The column will focus on legal issues — such as developing medical-legal areas and Ohio Supreme Court decisions — and on regulatory matters which affect physicians (for example, State Medical Board actions and Department of Health activities). Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

Chiropractor's Hospital Privileges Case Pending

By D. Brent Mulgrew, J.D., and Catherine C. Costello, J.D.,

Fort Hamilton-Hughes Memorial Hospital Center v. Fred M. Southard, D.C.
(Supreme Court of Ohio, Case #83-50)

Editor's Note: The primary purpose of the Ohio State Medical Association is to represent its members. The OSMA presents its members' concerns in many different forums, from the legislature to the courtroom. In the past few years, the OSMA has filed several *amicus curiae* briefs on cases pending in the Ohio Supreme Court. OSMA's Council authorizes the filing of *amicus* briefs in appellate cases that may have a significant impact on the way medicine is practiced in Ohio.

the Ohio Hospital Association, the Ohio State Medical Board and the State Board of Chiropractic Examiners.

Facts

Both Fort Hamilton-Hughes Memorial Hospital and Mercy Hospital are private non-profit hospitals. Each hospital has provisions in its bylaws that medical doctors, osteopaths, dentists and podiatrists are eligible to apply for medical staff privileges. The hospitals' X-ray and laboratory facilities are available only to members of the staff.

On several occasions, through clerical oversight, patients of Chiropractor Southard received radiology services at the hospitals. On one occasion, an electroencephalogram was performed. Such services were discontinued when the hospitals' administrative personnel learned of them.

The testimony at trial showed that the chiropractor had suitable X-ray equipment to produce X-ray films for review at his office. At the time of trial in 1981, Fred Southard conceded that despite the hospitals' actions, his practice had continued to prosper.

Analysis

When the two hospitals involved first went to court in 1979, they were asking the court to decide if their bylaws and policies excluding chiropractors were reasonable. They also asked the court to interpret a

Summary

Chiropractor Fred Southard sought to obtain outpatient X-ray services from two hospitals, Fort Hamilton-Hughes Memorial Hospital Center and Mercy Hospital. Neither hospital has provisions in its bylaws to permit chiropractors to order X-ray or laboratory services. When threatened with a lawsuit by the chiropractor, the hospitals went to court on May 18, 1979 seeking a determination that their policies regarding privileges were reasonable.

Judge Marrs of the Butler County Court of Common Pleas ruled in favor of the hospitals on April 15, 1981. Upon appeal, the Court of Appeals for Butler County upheld the trial court's decision for the hospitals (November 10, 1982). Fred Southard appealed to the Supreme Court of Ohio which has decided to hear the case.

Several groups have filed *amicus* briefs in the Supreme Court, including the Ohio State Medical Association,

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The Physician and Ohio Law

continued

section of the Ohio Revised Code, 3701.351 (formerly 3701.342), to determine whether the statute granted chiropractors the right to demand outpatient services from a hospital. This section of the Code reads as follows:

"The governing body of any hospital, in considering and acting upon applications for staff membership or professional privileges within the scope of the applicant's respective licensures, shall not discriminate against a qualified person solely on the basis of whether such person is certified to practice medicine or osteopathic medicine, or podiatry, or dentistry."

ORC 3701.351 (B)

The defendant chiropractor argued that the words "qualified person" included chiropractors, even though they were not specifically listed in the statute.

The trial court upheld the hospitals' policies of limiting privileges as being "reasonable, lawful and proper." Judge Marrs further stated that the governing boards of the hospitals were not acting arbitrarily in excluding chiropractors and that Ohio Revised Code 3701.351 "does not give the right of one licensed in the practice of chiropractic to receive services of the radiology or laboratory facilities of a private, non-profit hospital." This opinion was affirmed on appeal. The chiropractor appealed to the Ohio Supreme Court.

In his brief before the Supreme Court, he raises new issues not previously argued in the lower courts. Usually, only issues raised at trial court level can be argued on appeal. However, the new arguments he presents are significant enough that the OSMA and others feel that they should not go unanswered when the Supreme Court considers the case.

Dr. Southard argues that although Ohio statute 4734.09 limits a chiropractor's authority to treat, it does not limit his authority to diagnose; therefore any diagnostic tool, such as laboratory or X-ray exams, are available to him as a

matter of statutory right. The Board of Chiropractic Examiners, in its brief, carries this argument one step further, stating that any restriction on a chiropractor's authority to diagnose is a limitation on an individual's right to choose a desired method of health care delivery. Such arguments attempt to refocus the analysis of the case from the legal issues raised at the trial (i.e., the right of a hospital to restrict the granting of privileges) to the nebulous realm of a "public policy" case.

The Ohio State Medical Board, in its amicus brief, argues that the Board of Chiropractic Examiners makes a totally misleading interpretation of the chiropractic scope of practice statute. The OSMB believes the BCE analysis ignores the scheme of regulation established by the legislature for chiropractors. The Medical Board states that such a reading of the chiropractic statute could authorize a chiropractor to diagnose "mental illness, heart disease, pulmonary abnormalities, glandular disorders, and diseases of the skin."

The OSMA believes that this new issue is a red herring, raised to cloud the clear legal issues decided by the trial and appellate courts. The OSMA argues that even in instances where a chiropractor might be authorized by statute to use X-rays, there is no requirement that he do so. Certainly, the Ohio statute that allows for a certain type of treatment (i.e., chiropractic) does not also mandate that every hospital be required to provide these services to any applicant regardless of the decisions made by their governing boards and credentials committees.

The OSMA brief also argues that requiring hospitals grant access to a hospital's outpatient facilities would be misleading to the public. Because a hospital primarily provides medical and surgical care, all of which must by statute be under the supervision of a physician member of the medical staff, a layperson could erroneously conclude that a chiropractor with access to the X-ray and laboratory has the blessing of the hospital to diagnose and treat beyond his scope of practice. Such reliance on the hospital's

granting of even limited privileges could create potential liability for the hospital.

The Supreme Court of Ohio has scheduled oral arguments this Fall. This column will apprise *Journal* readers of the decision in the case.

MEDICAL BOARD SECRETARY POSITION FILLED TEMPORARILY

The Ohio State Medical Board voted to approve Dr. Henry Cramblett as the acting Secretary of the Board to replace Dr. Anthony Ruppertsberg, who passed away this summer. A permanent replacement will be voted on in the fall, since Dr. Cramblett will be away on sabbatical beginning in October. **OSMA**

* * *

The OSMA is registered as a 501 (C) (6) corporation with the Internal Revenue Service. To maintain such standing, the Association's activities must promote the common interest of the membership rather than provide specialized services to individuals. Consequently, this column will be devoted to general legal questions of interest to the membership.

D. Brent Mulgrew, J.D., and Catherine Costello, J.D. are in OSMA's Department of Legal Services and serve as OSMA's Staff Counsel.

Social Security recipients learn proper drug use

On July 1, the Food and Drug Administration (FDA) enclosed a message concerning the proper use of prescription medication to 36 million Social Security recipients. The FDA took the action as a result of two FDA-sponsored surveys that suggested there was a low level of communication between patients and their doctors and pharmacists concerning prescription drugs.

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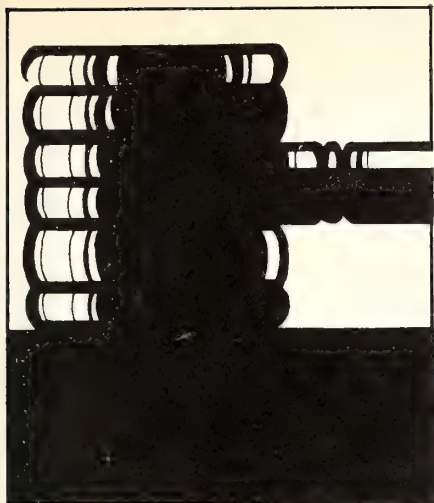
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council proceedings

July 15-17, 1983

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, July 16, 1983, at Sawmill Creek Lodge, Huron, Ohio.

Those present were: S. Baird Pfahl, Jr., M.D., Sandusky; A. Burton Payne, M.D., Ironton; C. Douglass Ford, M.D., Toledo; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Donavin A. Baumgartner, Jr., M.D., Cleveland; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; Thomas P. Price, Jr., M.D., Gallipolis; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Stella Brown, Dayton, President, OSMA Auxiliary; Stewart B. Dunsker, M.D., Cincinnati, OSMA Past President; Donald R. Goodwin, Senior Vice President, PICO; David W. Pennington, President, PACO; and David L. Jackson, M.D., Columbus, Director, Ohio Department of Health.

Those present from the OSMA Staff were: Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Robert E. Holcomb; Gail E. Dodson; David C. Torrens; Carol W. Mullinax;

Eric Burkland; Michael L. Bateson; Louis N. Saslaw; Catherine M. Costello; William E. Fry; Aristotle Hutras; Vickey McVay; and Carol Maddy.

The Council meeting resumed on Sunday, July 18. Everyone present on Saturday attended the Sunday portion of the meeting, with the exception of Stella Brown, David L. Jackson, M.D., and David Torrens. Joseph K. Gilmore, President of Physicians Insurance Company of Ohio, attended on Sunday to address the Council.

Announcements by President Pfahl

The President welcomed the Council to the Sawmill Creek area and introduced David L. Jackson, M.D., Ohio Director of Health, who addressed the Council.

Dr. Jackson described his previous work in critical care medicine and the transition into his position as Director of Health.

"Costs, access and quality" is the three-pronged problem facing medicine according to Dr. Jackson.

He expressed surprise at finding that only 6.7% of the Medicaid dollar is physician reimbursement.

He discussed the necessity to find new ways of delivering care without impacting on the quality of medicine.

The President read messages from Mrs. Carol C. Maddy, recipient of a 25-year award at the 1983 House of Delegates and Mrs. Elizabeth Anderson, 23-year member of the OSMA membership department staff, who retired June 30, 1983.

The Council accepted, with regret, the resignation of Dr. Edward G. Kilroy, as Fifth District Councillor, and appointed Dr. Donavin A. Baumgartner, Jr., Cleveland, to fill the vacancy and to serve until the next Annual Meeting of the House of Delegates. Dr. Baumgartner was recommended to fill the vacancy by the Fifth District Councillor.

Dr. Pfahl appointed the following committee to evaluate the OSMA leadership conference: Dr. Payne, Chairman; Dr. Abromowitz and Dr. Kloss.

Dr. Pfahl presented Dr. Ford with the gavel used by the latter during his term as President.

The Council selected two deceased members as recipients of the OSMA Distinguished Service Award for 1984: Dr. Milton Park, founding chairman of the OSMA Physicians Effectiveness Program, and Dr. Perry Ayres, former editor of the *Ohio State Medical Journal* and second chairman of the OSMA Physicians Effectiveness Program.

The posthumous awards will be presented at the 1984 House of Delegates.

Administration

The minutes of April 16, May 13 and May 16, 1983 meetings of the Council were approved.

Mr. Page outlined the following staff structure changes:

New: Department of Development and Member Services — Jerry J. Campbell, Director. The Students & Residents Division is transferred to the Department. Lou Saslaw will continue to operate that division and will staff OSMA Education and Research Foundation.

New: Department of Education; Specialty Society and Meeting Management — Gail Dodson, Director. David C. Torrens, Associate Director (who will also continue as Administrative Services Manager); Vickey McVay, Associate Director (who will continue to assist specialty societies); Carol C. Maddy, Assistant to the Director

Department of Finance and Membership

New Positions: Joseph C. Dusina, Manager, Data Processing; Brian Bruckelmeyer, Assistant Manager, Data Processing; Beth Bruckelmeyer, Membership Secretary; Carolyn I. Gary, Manager, Accounting.

Mr. Page requested and received approval for the exploration of the establishment of an OSMA Insurance Agency.

The Council voted to grant to the OSMA officers the authority to

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Council Proceedings

continued

explore a new membership service and potential revenue source.

PACO

Mr. Pennington presented a progress report of the development of Physicians Administrative Corporation of Ohio.

Foundation Report

Mr. Saslaw reported for the OSMA Education and Research Foundation, requesting the Councilors to encourage the billing of the Foundation voluntary assessment in the counties of their respective districts.

He announced various fund-raising programs contemplated by the Foundation.

The report was filed.

Nomination for President-Elect

The Council received a letter from the Montgomery County Medical Society, nominating Dr. Herman I. Abromowitz as a 1984 candidate for OSMA President-Elect.

Financial and Membership Department

Mrs. Wisse presented membership statistics.

Dr. Barr presented the treasurer's report and stated that he is searching for more competitive investment returns.

The report was filed.

Mrs. Wisse presented the written report of the Department, which was filed.

The Council discussed the need for re-emphasis on strengthening of the federation by maintaining membership in both county and state medical societies.

Dr. Kloss and Mr. Page were directed to meet with the Summit County Medical Society leadership on membership matters.

Auditing Appropriations Committee

Dr. Abromowitz reviewed the minutes of the July 15, 1983, meeting of the Auditing and Appropriations Committee. He presented an orientation summary of the work of the Committee and the financial operations of the Association.

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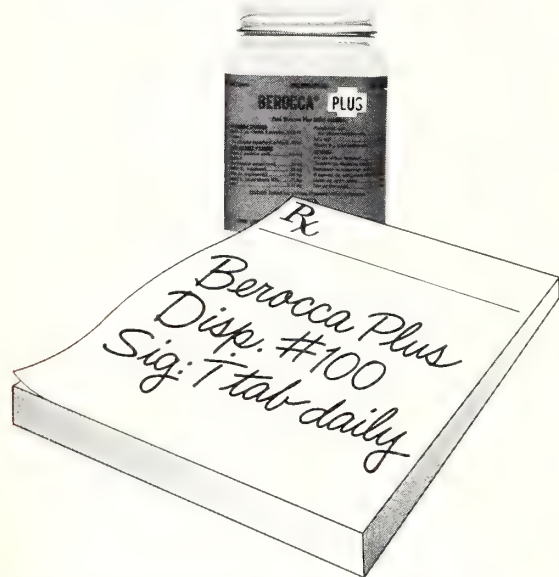
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Department of Education; Specialty Society and Meeting Management

Mrs. Dodson presented the report of the Department and indicated that the Ohio Psychiatric Association will soon be added to the list of organizations served by OSMA.

Annual Meeting

Mrs. Dodson announced May 18-23 as the 1984 Annual Meeting dates. Cincinnati will be the location.

Committee on Education

The minutes of the June 6, 1983, meeting of the Committee on Education were filed.

Committee on Emergency and Disaster Medical Care

The minutes of the Committee on Emergency and Disaster Medical Care meeting of March 31, 1983, were filed.

OSMA Resolutions

The Council directed the staff to require proper documentation of statements in House resolutions, including quotes, dates and actions described before the resolutions are accepted at OSMA headquarters and asked for the strict enforcement of the House requirements for fiscal notes.

Department of Government Relations

Mr. Gillen presented the written report of the Department.

A request from the Department for funds to conduct an information program on "DRG Prospective Reimbursement" was approved by the Council.

A motion to send AMA report on DRGs to the members of the Hospital Medical Staff Section was approved.

Committee on Cost Effectiveness

Mr. Fry presented the minutes of the April 11, 1983, meeting of the Committee on Cost Effectiveness and they were approved. A revised Committee Purpose Statement was approved.

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OSMA Task Force on Health Care

Dr. Irons presented the minutes of the June 29, 1983, meeting of the OSMA Task Force on Health Care.

Dr. Irons, Mr. Gillen and Mr. Burkland then discussed the Interim Report of the Governor's Commission on Ohio Health Care Costs and the minority report presented by the Ohio State Medical Association.

Dr. Irons also reviewed the Executive Summary of Governor Celeste's statement on his Commission on Health Care Costs presented July 8, 1983.

Dr. Jackson reviewed the Governor's program from the standpoint of cost, quality and access to care and input from the Health Department. He expressed the opinion that there would be a major commitment from the Ohio Department of Health to health care policy matters. Policy decisions on how Medicaid funds are allocated will be included.

He spoke of the moratoriums on certificate of need while the Department assesses the matter of determining needs on a rational basis.

He announced negotiations with the Federal Government for the management of the National Health Services Corps.

The minutes of the OSMA Task Force on Health Care were accepted and were filed.

The Council authorized the Task Force to continue its investigation into delivery of health care and reimbursement policies and to develop a plan.

Department of Development and Member Services

Mr. Campbell presented the written report of the Department.

AMA Delegation

Mr. Campbell pointed out that the report of the AMA Delegation had been distributed in advance of the Council meeting.

PICO

Mr. Goodwin, as the liaison

between PICO and Council, briefly addressed the Council.

Mr. Joseph K. Gilmore, President of PICO, addressed the Council, discussing the OSMA Group Professional Liability Policy. He noted that the group policy has saved the OSMA certificate holders more than three million dollars since inception on July 1, 1982, but that a rate increase would have to be instituted in the near future.

Department of Health Education

Mr. Clinger presented the written report of the Department.

He discussed the October 15-16, 1983, "Third Ohio Conference on the Impaired Physician."

Environmental Liaison Committee

The minutes of the April 20, 1983, meeting of the Environmental Liaison



The Preventive Medicine and Health Institute with Harding Hospital Presents

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BODY/MIND CONNECTION

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treatment & prognosis

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Bernard S. Siegel, M.D., F.A.C.S.

Assistant Clinical Professor of Surgery, Yale Medical School
Founder: Exceptional Cancer Patient Program

Ivan G. Podobnikar, M.D., F.A.P.A.

Founder & Medical Director, Cancer Counseling and Research Center
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Friday, November 11, 1983

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The Preventive Medicine & Health Institute

1460 W. Lane Ave., Columbus, Ohio 43221 (614) 488-5971

Approved for 4 Hours Category 1 CME Credit

Committee were presented by Mr. Clinger.

The Council referred the position paper on the "environment" the Committee for further study and restatement.

Committee on Mental Health

The minutes of the April 24, 1983, meeting of the Committee on Mental Health were presented. The Council approved the following recommendations:

1. That Director Hyde be invited to meet with the Committee;
2. That the Department of Mental Health be urged to place physicians in charge of treatment processes; and
3. That physicians in community or state mental health systems should not write or discontinue prescriptions unless they know the patient.

The Committee report was accepted.

OSMA/ONA Liaison Committee

The June 2, 1983, minutes of the OSMA/ONA Liaison Committee were presented by Dr. Dunsker, who discussed current developments in the nursing profession.

The report was filed.

Department of Staff Counsel

The written report of the Department was presented by Mr. Mulgrew.

He discussed in detail the *Oliver* case, a recent judicial decision of the Ohio Supreme Court affecting the Statute of Limitations applicable to medical malpractice cases.

Federal Legislative Update

Mr. Mulgrew announced that the Federal health care for the unemployed may be funded by freezing the cap on Medicare reimbursement for one year if present

proposals are adopted.

End stage renal reimbursement (ESRD) rules have been adopted effective August 1. He then discussed the handicapped infants rule (Baby Doe).

State Medical Board

Ms. Costello discussed upcoming vacancies on the State Medical Board. One involved the "consumer representative" position presently held by Mr. Walter Paulo. Another vacancy exists due to the death of Dr. Anthony Ruppberg, Secretary of the Board.

A number of issues currently under discussion by the Board were reviewed for the information of the Council, including supervision of nurse anesthetists and EMT supervision.

Administrative Rules

Ms. Costello informed the Council concerning Welfare Department rules on nurse widwife reimbursement.

Department of State Legislation

Mr. Burkland and Mr. Bateson presented the report on State Legislation.

It was indicated that the \$26-billion budget is the largest in the history of the State.

The following legislative proposals were reviewed: Optometry Bill; Nurse Midwife Co-Admission Bill; Institutional Employment of Physician Assistants; Pharmacy Practice Act; Living Wills; Requiring CON Hearings in the Community; and Administration of Epinephrine by EMT-As.

Department of Communications

The written report of the Department of Communications was presented by Ms. Doll.

The Council expressed appreciation to Ms. Gina Cummins, who has resigned as editor of *Synergy*.

Ms. Mullinax reported on the 20-page OSMA supplement in the July 18 issue of the *Columbus Citizen-Journal*, and discussed plans for future editions in other newspapers.

continued on page 783

THE OHIO PAIN AND STRESS TREATMENT CENTER

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Council Proceedings

continued

Department of Marketing & Field Service

The written report of the Department of Marketing & Field Service was presented by Mr. Holcomb.

Councilor Reports

The Councilors reported on the activities in their respective districts.

Dr. Irons discussed the 11th District "information day" to be held August 27 for an update on:

1. Health Systems for the '80's
2. Business Coalition
3. Drug Information and the State Medical Board
4. Medical Student increases; allied personnel increases
5. Significant Legislative Proposals

Legal Counsel Report

Mr. Pohlman presented the report of Legal Counsel and discussed several pending matters and lawsuits.

Auxiliary Report

Mrs. Stella Brown presented the written report of the Auxiliary, and discussed upcoming programs involving membership recruitment.

The report was filed.

There being no further business, the Council Meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

Fat babies, fat adults

Fat babies turn into fat adults, according to an article in a recent issue of *American Family Physician*.

About 45 percent of overweight infants become obese adults, with obesity being the most common nutritional problem among children in this country. In addition, the authors, who are members of the Eating Assessment and Treatment team at Georgetown University Medical Center, say the problem of excess poundage runs in families.

Candidates for nutritional therapy...

5,000,000 hospital patients with infections.¹

Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.²



Berocca Plus. A balanced formula for prophylactic or therapeutic nutritional supplementation. Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

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1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME: Philadelphia, Lea & Febiger, 1980, p. 1114

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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets—bottles of 100.



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The Memorial Fund of OMERF provides both a meaningful and personal way of paying tribute to the honored memory of the deceased.

Memorial gifts may be made payable to the Ohio Medical Education & Research Foundation (OMERF) and sent to the OSMA office. All gifts are acknowledged both to the donor and to the family of the deceased.

Below is a list of those individuals and groups who have contributed money to the Ohio Medical Education and Research Foundation in memory of Anthony J. Ruppertsberg, M.D.:

Dr. and Mrs. Homer Anderson, *Columbus*
Dr. and Mrs. Harley M. Blank, *Columbus*
Dr. and Mrs. John Boutselis, *Columbus*
Central Ohio Colon and Rectal Center, *Columbus*
Dr. and Mrs. Charles Diesam, *Columbus*
Gail and Walter Dodson, *Columbus*
Pamela Dolby, *Columbus*
Mr. and Mrs. J.W. Endres, Jr., *Mt. Sterling*
Ms. Ann Gauger, *Fairborn*
Mary Ann Johnson, *Columbus*
Dr. and Mrs. R.E. Johnstone, *Cincinnati*
Roberta Joseph, *Columbus*
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Mr. Harlan S. Kirk, *Wheaton, Illinois*
Mr. and Mrs. George Lowery, *Orient*
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Mr. and Mrs. Hart F. Page, *Worthington*
Mr. and Mrs. James E. Pohlman, *Columbus*
Price, Flynn, Hill, Deibel and Co., CPAs, *Columbus*
Col. Carl J. Pritchard, *Columbus*
Tony Samn, M.D., *Columbus*
Karl Schaeffer, M.D., *Columbus*
St. Ann's Hospital Medical Staff, *Columbus*
University Club, *Columbus*



Continuing Education Programs

October

RICHARD L. FULTON MEMORIAL LECTURE: October 18; Susan H. Edwards Auditorium, Riverside Methodist Hospital, Columbus. Speaker: Alvin Tarlov, chairman, Department of Medicine, University of Chicago. Dr. Tarlov, who served as chairman of the GMENAC study will speak on future supply, and provide an update on the GMENAC report. Contact: Linda Yoder, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus, Ohio 43214, 614-261-5776.

CENTRAL OHIO POISON CENTER CONFERENCE: October 12; Baxter Auditorium, Children's Hospital, Columbus; sponsor: Children's Hospital, Columbus; 6 credit hours; fee: \$50; contact: Educational Program Coordinator, Department of Education, Children's Hospital, 700 Children's Drive, Columbus 43205, phone: 614/461-2914.

December

MODERN ADVANCES IN HERNIA SURGERY: December 1; St. Elizabeth Hospital Medical Center, 1044 Belmont Avenue, Youngstown; 4 credit hours; no fee; contact: Rashid Abdu, M.D., Director of Education, St. Elizabeth Hospital, 1044 Belmont Avenue, Box 1790,

Youngstown 44501, phone: 216/746-7211.

CANCER CENTER SYMPOSIUM — 1983: December 7; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: \$70, \$35 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

PERSPECTIVES IN OPHTHALMOLOGY: December 2-3; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$190, \$95 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

NUTRITION: December 15; St. Elizabeth Hospital Medical Center, 1044 Belmont Avenue, Youngstown; 3 hours credit; No fee; contact: Rashid Abdu, M.D., Director of Education, St. Elizabeth Hospital, 1044 Belmont Avenue, Box 1790, Youngstown 44501, phone: 216/746-7211.

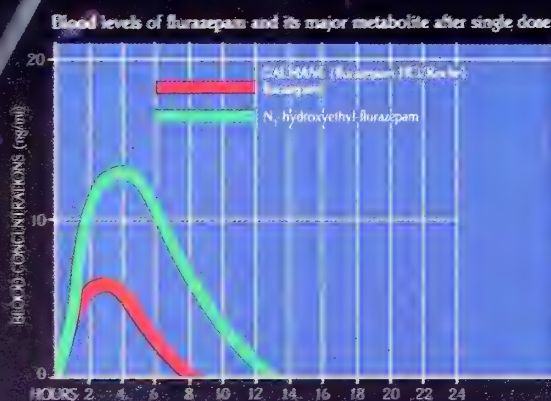
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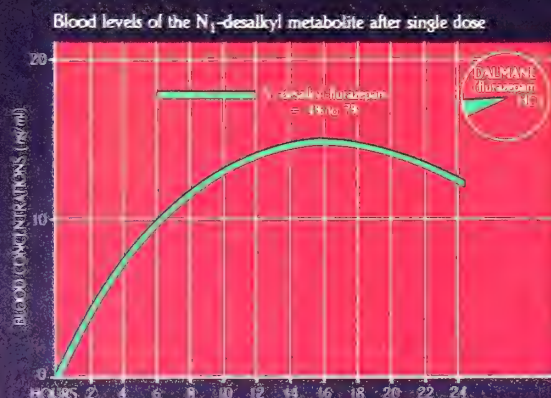
Only Dalmane® has the hypnotic profile (flurazepam HCl/Roche) to provide these benefits



The profile



Adapted from Data on file.¹ Kaplan et al.² Greenblatt et al.³ and de Silva et al.⁴



Adapted from de Silva et al.⁴

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Two short-half-life hypnotic components appear rapidly and are rapidly eliminated

Dalmane has a pharmacokinetic profile that sets it apart from all other hypnotic agents.

First, there is the active parent compound flurazepam, which appears rapidly in the blood after ingestion and has a half-life of about 2.3 hours. Then there is the major metabolite—N₁-hydroxyethyl-flurazepam—which accounts for 22% to 55% of an average dose in urine. This compound also appears rapidly in the blood, where it has a half-life of two to three hours.¹⁻⁴

Another metabolite accounts for only 4% to 7% of dose in plasma

N₁-desalkyl-flurazepam appears more slowly in serum and has a longer half-life (47 to 100 hours).⁴ This metabolite accounts for only 4% to 7% of an average dose of Dalmane in plasma.¹ It accumulates to steady state within seven to ten days⁴ and disappears gradually after discontinuation of therapy.

The benefits

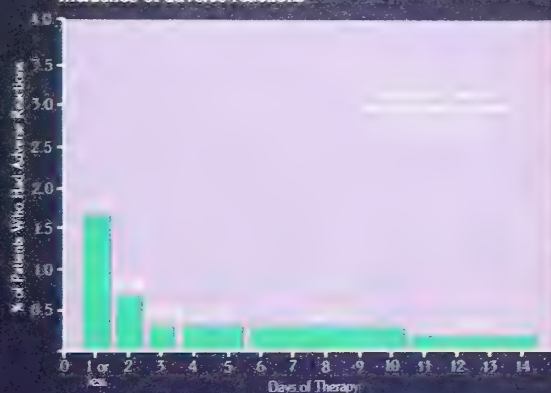
Dalmane (flurazepam HCl/Roche)
remains effective yet rarely causes
morning hangover

In objective sleep laboratory studies, Dalmane proved more effective than any other hypnotic tested.^{5,6} Patients with insomnia fell asleep 44% sooner on the first three nights of Dalmane therapy and 56% sooner on nights 12 to 14.⁶ Total wake time decreased significantly on the first nights of therapy, and tolerance did not appear to develop for up to 28 consecutive nights of treatment.⁵ Even after four weeks, Dalmane was still significantly more effective than placebo or other hypnotics, some of which lose effectiveness on chronic dosing.^{5,7}

Morning hangover, moreover, was rare with Dalmane. In a study of 2542 patients treated in the hospital, only 3.1% reported adverse reactions after Dalmane treatment. Most of the side effects occurred after the first night of treatment; the incidence diminished as therapy continued.⁸

Caution patients about driving or drinking alcohol during therapy. Because the risks of dizziness, oversedation and ataxia increase with higher dosages in the elderly and debilitated, the dosage should be limited to 15 mg in these patients. Dalmane is contraindicated in pregnancy.

Incidence of adverse reactions



Adapted from Greenblatt et al.⁸

And Dalmane (flurazepam HCl/Roche)
avoids rebound insomnia

If patients sleep worse when medication is discontinued than they did before treatment began, the value of hypnotic therapy is clearly questionable. Such rebound insomnia has been reported with certain hypnotics that have short half-lives.⁹⁻¹² Yet this problem does not occur with Dalmane as proven in eight of eight sleep laboratory studies.¹¹ Even after two weeks following discontinuation of Dalmane, rebound insomnia had not occurred.⁵

Dalmane. The complete hypnotic that stands apart from all others.



Dalmane®
flurazepam HCl/Roche
15-mg/30-mg capsules
stands apart



References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kaplan SA et al: *J Pharm Sci* 62:1932-1935, Dec 1973. 3. Greenblatt DJ et al: *Clin Pharmacol Ther* 17:1-14, Jan 1975. 4. de Silva JAF, Bekersky I, Puglisi CV: *J Pharm Sci* 63:1837-1841, Dec 1974. 5. Kales A et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 6. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977, and Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 7. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 8. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 9. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 10. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 11. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 12. Greenblatt DJ et al: *Sleep* 5(Suppl 1):S18-S27, 1982.

Dalmane®
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. Adults: 30 mg usual dosage; 15 mg may suffice in some patients. Elderly or debilitated patients: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



New Members

BELMONT

Fausto Jose Lazo, Lansing
Sharon Marso Lazo, Lansing

CLARK

Marvin H. Williams, Jr., Springfield

CUYAHOGA (Cleveland unless noted)

Aquilio C. Agliam
Marcial M. Aldana
Yong S. Chung
Maurice E. Coffey
David Fisher
Donald E. Fry
Marilee L. Gallagher
Robert L. Hinnes
Anthony L. Imbembo
James Loveland
Ali Moayeri
Ajit C. Shah, Eastlake
Arunika N. Shah
Eric Sobel

FAIRFIELD

Richard Usilton, Lancaster

FRANKLIN (Columbus unless noted)

Madhu Bhatia, Dublin
Mary Beth Butcher
Thomas R. Carter
Mark L. Cunningham, Dublin
Randolph R. Evans
Leonard R. Ferguson, Dublin
John A. Fisher
Michael H. Fritsch
Allan Kelly
Cheryl L. Lee
Jane M. Leiby
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Robert M. Sholtes, Worthington
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Christopher Englert
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Sheree Clark, Norwalk
Carl W. Lovell, Norwalk

JACKSON

Nirmal K. Dutta, Oak Hill

JEFFERSON

Ramona M. Murty, Steubenville
Narendra Patel, Steubenville

KNOX

Lewis Eastman Carroll, Mt. Vernon

LUCAS (Toledo unless noted)

Fernando Crotte, Jr.
Jyoti Pandya
Lalitha Rao

MAHONING

Shokat Fatteh, Girard

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SUMMIT

Judy Wolk, Akron

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CLINICAL NOTES

Edited by Karen S. Edwards

Emotional Difficulties tied to right hemisphere damage

Two Harvard Medical School researchers hypothesize that damage to the right hemisphere of the brain suffered in early life, or inherited, may lead to chronic emotional difficulties. They report on 14 patients with a behavioral syndrome, beginning early in life, characterized by interpersonal problems, shyness, visuospatial disturbances, and deficits in communication abilities. "Examination revealed neurologic and neuropsychological signs consistent with right-hemisphere dysfunction," the researchers say.

— **Archives of Neurology**
Vol. 40, No. 8,
pages 463-468

Mercury exposure mimics Lou Gehrig's disease

Exposure to mercury can produce symptoms that mimic amyotrophic lateral sclerosis (Lou Gehrig's disease), report Charles R. Adams, M.D. and colleagues from the University of Kansas Medical Center in Kansas City. The physicians tell of a 54-year-old man with a number of symptoms, including wasting of upper arms and numbing of hands, who was first thought to have ALS. It was later

determined that he had been exposed to liquid mercury; symptoms disappeared spontaneously, the researchers add.

— **Journal of the
American Medical
Association**
Vol. 250, No. 5,
pages 642-643

IUD Users more at-risk for pelvic inflammatory disease

A group of Boston researchers has found evidence confirming that women who use intrauterine contraceptive devices (IUDs) are at greater risk for developing pelvic inflammatory disease.

Pelvic inflammatory disease, which usually results from sexually transmitted infections, accounts for 30 to 40 percent of infertility and about half of all ectopic pregnancies.

David W. Kaufman, M.S., and colleagues at Boston University Medical School studied 460 premenopausal women using some form of contraception and found that current IUD users were nine times more likely to contract pelvic inflammatory disease than were users of other contraceptives.

— **Journal of the
American Medical
Association**
Vol. 250, No. 6,
pages 759-762

Dapsone used to control spider bites

Dapsone, a substance generally used to control leprosy, has been found useful in treatment of skin lesions caused by spider bites, say Lloyd E. King, Jr., M.D., Ph.D., and Riley S. Rees, M.D. The Nashville physicians, associated with the Veterans Administration and Vanderbilt University medical centers say,

"Judicious use of dapsone, starting with a low dose with careful follow-up, should be useful in eliminating necrotic skin ulcers produced by the brown recluse spider bite."

— **Journal of the
American Medical
Association**
Vol. 250, No. 5,
page 648

New method for feeding patients unable to swallow

A new method for feeding patients who are unable to swallow has been developed by three Cleveland-based surgeons. Reporting on use of the method for 150 patients, the researchers say that complications were held to only 10 percent, a strikingly low percentage of morbidity for gastric-tube-fed patients.

Called "percutaneous endoscopic gastrostomy," the method was developed in 1979 by Jeffrey L. Ponsky, M.D., and colleagues Michael W.L. Gauderer, M.D., and Thomas A. Stellato, M.D., from Case Western Reserve University School of Medicine. The procedure involves passing a feeding catheter through a gastroscope down the mouth and esophagus into the stomach and out the stomach and abdominal walls.

"We have encountered no instances of gastric outlet obstruction secondary to catheter migration, no hemorrhage and no leakage around the catheter," says the physicians. "Our experience with children has been most gratifying, since a gastrocolic fistula was the only major complication. This compares favorably with others' experience using standard gastrostomy."

Another major advantage of the procedure comes from avoidance of general anesthesia, with its attendant risks. The researchers were able to place the gastric tube using a combination of local and topical spray anesthesia in the majority of cases.

— **Archives of Surgery**
Vol. 118, No. 8
pages 913-914

"I can do things that I couldn't do for 3 yrs. including joining the human race again."

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[] as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

Quoted from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procordia, nor will they all respond to the same degree.

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for the varied faces of angina

PROCARDIA[®]
(NIFEDIPINE) Capsules 10 mg

*Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA brief summary on adjoining page.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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LABORATORIES DIVISION
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Obituaries

PHILIP DREZNICK, M.D., Fairfield; State University of New York College of Medicine, 1965; age 43; died June 27, 1983; member OSMA and AMA.

STUART B. FISHER, M.D., Cleveland; Ohio State University College of Medicine, 1955; age 54; died July 16, 1983; member OSMA and AMA.

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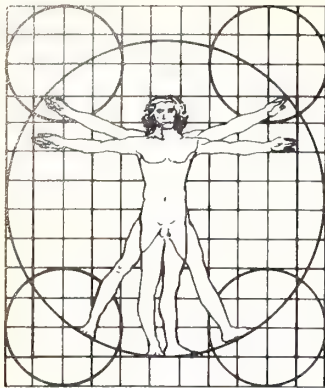
LOTHAR RAMINS, M.D., Tacoma, Washington; Latvijas Universitate Medicinas Fakultate, Riga, Latvia, 1931; age 79; died June 23, 1983; member OSMA and AMA.

FRANK ROGERS, M.D., Cleveland; Marquette University College of Medicine, Milwaukee, Wisconsin, 1933; age 78; died July 10, 1983; member OSMA and AMA.

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HAROLD R. THARP, M.D., Xenia; Indiana University School of Medicine, Indianapolis, Indiana, 1944; age 63; died July 20, 1983; member OSMA and AMA.



CLINICAL & SCIENTIFIC

DEPRESSION AS ILLNESS AND MOOD: THE IMPLICATIONS FOR DIAGNOSIS AND TREATMENT

Moshe Torem, M.D.*

The distinction between depressed mood which may be just normal sadness, and those cases where it may represent a depressive illness is very important.

The former usually lasts from minutes to hours or a couple of days, is responsive to environmental influences and is not accompanied by a lowered self-esteem or a sense of guilt, shame or self-derogatory thoughts.

The latter is a clinical psychopathological condition, in fact, the most common psychiatric disorder and which may very well respond to anti-depressant drugs. The former one on the other hand although very common does not respond to anti-depressants. The article deals with these two conditions and delineates ways of distinguishing one from the other and thus making the correct diagnosis. It also outlines indications for treatment and the rational use of anti-depressant medication.

To physicians, depression encompasses a wide range of moods, from normal sadness lasting minutes or hours and responsive to environmental influences to an illness with a persistent despondency refractory to environmental influences. The former is *not* a clinical psychopathological condition, although it may be mistaken for one. The latter is the most common psychiatric disorder in adults, 15 percent to 30 percent of whom may experience a clinical depression sometime in their lives.¹ Most of those afflicted with a depressive illness are first seen by their primary care physician. Many times these patients are misdiagnosed and, as a result, inappropriately treated. Lack of awareness of the difference between normal sadness and the illness depression may lead to treatment which is either too timid or too aggressive, either of which may prolong suffering and increase the risk of complications.

There are important distinctions between normal sadness or unhappiness and depressive illness. The former is *not* accompanied by a loss of self-esteem or guilt. This is also true for states of bereavement or mourning. The bereaved person's self-esteem is intact. The person in grief still feels worthwhile. The person who suffers from a depressive illness also suffers from a lowered self-esteem which may be and usually is accompanied by feelings of guilt, inadequacy, self-depreciation, helplessness, hopelessness and shame. Central to the distinction between sadness, grief and depressive illness is the absence of lowered self-esteem and

guilt and the presence of hope in the former and the opposite of these in the latter.

The presenting symptomatology of depression may be only psychological symptoms such as sadness, anxiety, guilt and lowered self-esteem; only physical symptoms; or a mixture of both. The physical manifestations of depressive illness include sleep and appetite disturbances, gastrointestinal complaints, constant fatigue, palpitations, headaches, and genitourinary problems.² Such symptoms also can be complained of by unhappy people. However, two important facts help to differentiate those who are unhappy and not ill from those who have a depressive illness. Depression can be diagnosed if the signs and symptoms cited thus far have been present for two or more weeks. A shorter duration of symptomatology may indicate a transient depressive mood and not necessarily illness. Depressive illness can be diagnosed if attention is paid to the patient's attitude toward his symptoms. The sad person is distressed by his symptoms but because he has hope, he expects to recover. The depressed person is a pessimist and lacks hope. To him the signs and symptoms experienced are ominous. He fears the worst and doubts that he will recover.

If the above manifestations of a disorder generate suspicions of a depressive illness, the primary care physician should look for cognitive changes, such as impaired concentration and memory, and a decline in interests, along with complaints of psychomotor retardation (such as morning is the worst time of the day and everything is an effort, so many usual activities are postponed). Finally, the patient should be asked about death wishes and suicidal thoughts. Eliciting the physical, psychological and emotional symptoms that are confirmatory of the illness depression requires little time. In addition, whenever possible, the primary care physician should get additional history from the patient's family who often can provide invaluable confirmatory diagnostic data.

Before treating a depressive illness, a physician should do a physical examination, during which careful observation of the patient's appearance, posture, speech, movements, dress and grooming may detect more evidence of depressive illness. In addition, the physical examination may disclose evidence of thyroid dysfunction or other physical conditions that could be re-

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sponsible for a secondary depression that must be differentiated from a primary affective illness. The latter includes depressions which are not associated with a psychosocial trauma or loss, a physical disease, or another psychiatric illness such as schizophrenia.³

Patients with a primary affective illness may have a history of previous episodes of only depression, only elation or mania, or both. When the patient has had elation and depression, the illness is called bipolar; if the patient has had only depression, the illness is classified as unipolar. Because antidepressant drugs may cause a switch from depression to mania and because some bipolar patients are best treated with lithium carbonate, if bipolar illness is suspected, it may be helpful to obtain a psychiatric consultation to confirm the diagnosis and to consider treatment with lithium alone or in combination with an antidepressant.

Secondary depression may occur in conjunction with a medical problem, the first manifestation of which may be signs and symptoms of depression. Somatic diseases often associated with depression include endocrine disorders, malignancies, CNS diseases, infectious diseases, electrolyte disorders and nutritional deficiencies.

Some depressions can be drug-induced. For example, it is not uncommon for patients on certain antihypertensives to become quite depressed. Reserpine, steroids, oral contraceptives, beta-blockers and other commonly used prescription drugs may precipitate a depression in some susceptible individuals. The knowledge that both physical disorders and certain drugs may produce secondary depression may help the primary care physician avoid unnecessary diagnostic workups and unsuccessful treatments.

Besides the situation mentioned earlier in which a psychiatric consultation may be advisable, there are others in which this may be necessary. Patients who are severely withdrawn and have neglected personal hygiene, or who have lost a significant amount of weight over a short period of time should be evaluated by a specialist. Hallucinations or delusions indicate severe depression, the management of which may require hospitalization. Suicidal thoughts, with or without a history of previous attempts, also warrant psychiatric consultation. If the patient has been seen by the primary care physician for more than one month without improvement, or if for any reason the primary care physician feels unsure about patient management, it may be wise to obtain a psychiatrist's opinion.

The primary care physician should take the time to inform the patient about an intended referral, since the success of any referral often depends on how well the patient is prepared for it. Discuss the reasons for the referral, explaining that it is the physician who wants the opinion of an expert on the best ways to proceed with treatment. Tell the patient that the consultation will be with another doctor whose specialty is in the area of psychiatry which includes depression. It is important to reassure the patient that the primary care physician will continue as the main source of health care, and that the patient is not being deserted or abandoned. This verbal reassurance can be very effective if the patient's next appointment is then scheduled immediately. Discuss what the interview with the psychiatrist will be like. Advance explanations alleviate unrealistic fears by letting the patient know what to expect. A few words about the psychiatrist's professional qualifications, experience, and relationship with the primary care physician are also reassuring, and improve the patient's compliance.

Initiation of treatment by the primary care physician may combine both psychotherapy and medication. Some practitioners, not trained in the skills of in-depth psychotherapy, may

wonder what to say to the patient. However, medication, accompanied with the proper words, increases the successful outcome of therapy. The principles of supportive psychotherapy have been discussed by Ayd, Campbell, Kraines, Catelluovo-Tedesco, and others.²⁻⁵ These authors stress the importance of establishing good rapport with patients by listening to their complaints, even if these complaints are familiar. Depressed patients need constant reassurance. Communicate understanding by acknowledging the patient's concerns, restating them, and asking for clarifications if necessary. Restore hope by explaining that depression is a common illness for which there is treatment, and that recovery from this temporary condition can be expected. Alleviate fear by discussing the treatment plan, including the use of tests, medications, and consultants.

Some patients, especially those who are depressed following a major loss, may benefit from ventilation and catharsis. By talking with the patient about the lost person and the patient's relationship with that person, the physician acts as an understanding listener and facilitates communication. If a patient cries, be supportive. Offer a box of tissues and ask about the patient's thoughts and feelings when the crying started.

Many depressed patients need decision-making guidance. Suggest recreational, manual, intellectual or aesthetic activities to help structure the patient's day, and discuss these activities during the next visit. Joint meetings with a spouse or other family members may be helpful, particularly when marital conflict is identified. In the case of a primary depression, the physician should urge postponement of any major decisions until the patient has recovered.

Antidepressant Drug Therapy

Until recently, American physicians could choose between only two types of antidepressant drugs: (1) the monoamine oxidase inhibitors (MAOIs) such as phenelzine and tranylcypromine, and (2) the tricyclics (TCAs) such as imipramine and amitriptyline. Today, many second generation antidepressants are available, including the tetracyclic maprotiline which, although new in the U.S., has stood the test of time during 15 years clinical experience outside the U.S. Like the TCAs, maprotiline has been demonstrated to be superior to placebo in the treatment of all types of primary depression (neurotic, anxious, agitated and retarded).⁶ In addition, patients unresponsive to or intolerant of TCA therapy may tolerate and respond to maprotiline.⁶

For many patients, especially the elderly and those with various types of cardiac disorders co-existing with depression, the anticholinergic and cardio-vascular side effects of antidepressants must be taken into consideration. Anticholinergic effects include dry mouth, blurred vision, constipation, delayed micturition and sinus tachycardia. All TCAs may produce varying degrees of cardiovascular effects — postural hypotension, premature atrial or ventricular beats, pedal edema, and ECG abnormalities (e.g. ST-segment depression, flattened or inverted T-wave, QRS prolongation).^{7,8} By contrast, in the past 15 years, an enormous amount of data on the cardiovascular effects of maprotiline have been gathered.^{6,9,10} These data document that maprotiline's cardiac effects are dose-related; low doses (50 mg in divided daily doses) rarely cause any clinical or ECG evidence of cardiotoxicity, even in patients with various types of cardiovascular disorders. The higher the dose, especially single doses, the more likely is maprotiline to cause alterations in cardiac rate, rhythm and conduction mechanisms. Clinical experience outside the U.S. has verified that low dose initial maprotiline therapy (25 mg b.d.) followed by gradual increments of 25 mg

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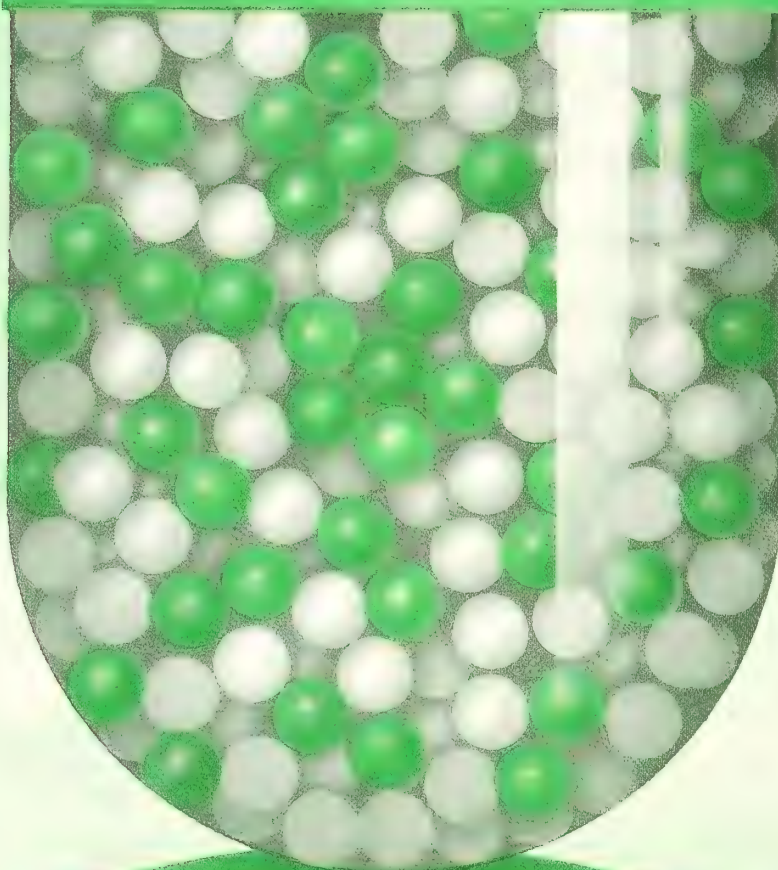
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Before prescribing, see complete prescribing information. The following is a brief summary.

DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.

INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage in pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated patient, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

Slight to moderate drowsiness occurs relatively infrequently with Chlorpheniramine Maleate. Other possible side effects common in antihistamines in general include perspiration, chills, dryness of mouth, nose and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteresis, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

DOSAGE AND ADMINISTRATION: Dosage should be individualized according to the needs and response of the patient. Adults: one capsule every 8 to 12 hours not to exceed 3 capsules daily. Not for use in children under 12 years of age.

OVERDOSAGE: Treatment of the signs and symptoms of overdosage is symptomatic and supportive. In the event of overdosage, emergency treatment should be started immediately.

Treatment: The patient should be induced to vomit, even if emesis has occurred spontaneously. Vomiting by the administration of ipecac syrup is a preferred method. However, vomiting should not be induced in patients with impaired consciousness. Stimulants (analeptic agents) should not be used. Vasopressors may be used to treat hypotension. Short-acting barbiturates, diazepam or paraldehyde may be administered to control seizures. Hyperpyrexia, especially in children, may require treatment with tepid water sponge baths or a hypothermic blanket. Apnea is treated with ventilatory support.

HOW SUPPLIED: Green and clear capsules with green and white beads. Bottles of 100 tablets. NDC 0524-0031-01

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permits safe and beneficial maprotiline therapy for depressed cardiac patients.

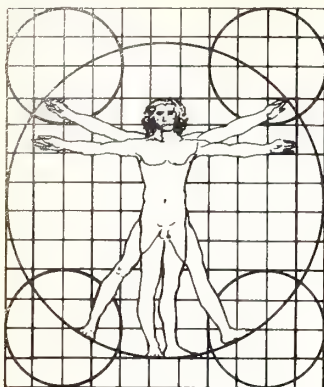
Patients with bronchial asthma, prostatic hypertrophy, or organic brain diseases should be treated with an antidepressant with minimal anticholinergic activity, an asset of maprotiline compared to TCAs. Furthermore, if a patient needs sedation in addition to fewer anticholinergic effects, maprotiline or trazodone may be a good choice. Doxepin and maprotiline appear to have fewer arrhythmogenic effects and thus may be among the safer antidepressants for patients with heart disease. Anath,¹¹ who has reviewed the cardiovascular effects of maprotiline, has written: "In view of the adverse cardiovascular effects of untreated depression and of the relative safety of low doses of maprotiline, depressed patients with heart disease need not and should not be denied the potential benefits of cautious maprotiline therapy, since its risks are small."

The most common antidepressant prescription errors are failure to utilize adequate dosage and failure to continue treatment for an adequate length of time. Antidepressants such as maprotiline are usually initiated with 25 mg b.i.d. or t.i.d. Dosage is then gradually increased 25 mg every third day until a total daily dosage of 150 mg is reached. After one week on divided doses the entire daily dosage may be given in a single dose in the evening or one hour before sleep, thus increasing the patient's compliance without reducing efficacy.⁶ Elderly patients should be given only about half the recommended adult dosage.

Antidepressant medication should be given for at least four to six weeks in the effective dosage range (e.g. maprotiline 150-300 mg/day) before nonresponse can be determined. After initial improvement, to preclude relapse, treatment should be continued for three to six months. Thereafter, gradual dosage reduction should be started. A few patients may need maintenance treatment for months or years to obviate recurrent depression that may be severe enough to require hospital treatment. Maintenance antidepressant therapy has proven to be sufficiently safe and effective, so much so that it is being used with increasing frequency around the world.

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CLINICAL & SCIENTIFIC

SULFHEMOGLOBINEMIA ASSOCIATED WITH PHENAZOPYRIDINE (PYRIDIUM®) ADMINISTRATION

Review of the literature

Perry F. Smith, M.D.; Gerald A. Palermo, M.D.; and John W. Vester, M.D.

Sulfhemoglobin is an abnormal heme pigment which can cause cyanosis. It is usually acquired as a toxic effect of certain drugs. Phenazopyridine is not recognized as a drug which causes sulfhemoglobinemia and cyanosis. A patient is presented who developed cyanosis from sulfhemoglobinemia in association with phenazopyridine administration. The chemistry, identification, and etiology of sulfhemoglobinemia is reviewed, and a possible explanation for sulfhemoglobin production by phenazopyridine is presented. A review of the literature reveals very few reported cases of sulfhemoglobinemia from phenazopyridine. The possible reasons for its rarity are discussed. Phenazopyridine appears to be a drug that can cause sulfhemoglobinemia.

Key words: Sulfhemoglobinemia, Phenazopyridine, Pyridium®, Cyanosis.

Phenazopyridine (Pyridium®) has been used for over half a century, first as an antiseptic and now as an analgesic for the genitourinary tract. In spite of its widespread use, the incidence of adverse reactions appears to be low. Nevertheless, there are multiple reports documenting the more serious side effects, including hemolytic anemia,¹⁻⁴ hepatitis,⁵⁻⁷ acute renal failure,^{4,5,8-10} and methemoglobinemia.^{2-6,8,11-15}

Sulfhemoglobin is an abnormal heme pigment, usually drug-induced, which can cause cyanosis when present in sufficient quantity. There is one report in the English literature of trace amounts of sulfhemoglobin following the use of phenazopyri-

dine.¹ The medical history of a patient with cyanosis from significant sulfhemoglobinemia, most probably secondary to phenazopyridine is presented.

Patient's History and Findings

A 76-year-old man was seen in the emergency room of the Good Samaritan Hospital complaining of burning at the tip of his penis of two months duration. His lips and nail beds were noted to be cyanotic, and he was admitted for evaluation. He had no complaints of dyspnea. Medications included phenazopyridine 200 mgs three times daily, Urecholine® 25 mgs four times daily, Darvocet-N 50® prn, Hydrodiuril® 25 mgs daily, and potassium chloride 40 meq. daily. The phenazopyridine had been started twenty-four days earlier at which time cyanosis was absent. Past medical history, family history, and system review were non-contributory.

On physical examination, the vital signs were normal. He had a generalized slate grey color to his skin, with marked cyanosis of the lips and nail beds. Other positive findings included bilateral arcus senilis, a right carotid bruit, left inguinal hernia, and slightly enlarged prostate. The rest of the exam was unremarkable.

Laboratory studies included a hemoglobin of 12.3 gm% with normal indices. Reticulocyte count was 3.6%. White blood cell count and differential were normal. The blood urea nitrogen and serum creatinine were normal. The arterial blood gases showed a P_{O_2} of 71 mm Hg, P_{CO_2} of 39 mm Hg, pH of 7.43, and 95% oxygen saturation. Urinalysis and urine culture were normal. Chest X-ray showed cardiac enlargement, and the electrocardiogram was normal. Further hematologic testing revealed a normal hemoglobin electrophoresis, serum iron of 73 ug/dl, iron binding capacity of 235 ug/dl with 31% saturation, and a haptoglobin level of 19 mg/dl. The P_{50O_2} was slightly elevated at 27.5 mm Hg, and the 2, 3-DPG level was normal at 5.4 umole/ml. Methemoglobin was slightly elevated at 2.6% of total hemoglobin. The sulfhemoglobin level as determined by the method of Carrico et al.¹⁶ was 2.27 gm%. On 5/31/78, the phenazopyridine was stopped, and the cyanosis slowly resolved over a period of weeks as the sulfhemoglobin levels dropped: 6/9/78 — 1.72 gm%, 6/15/78 — 1.40 gm%, 6/28/78 — 0.68 gm%, 7/25/78 — 0.30 gm%, 8/28/78 — 0.06 gm%, 4/12/79 — negative.

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Discussion

Cyanosis has multiple etiologies. Most commonly, it is a sign of low arterial oxygen tension resulting from cardiovascular or pulmonary disease. In the presence of a normal arterial Po_2 , however, the cyanosis may be secondary to methemoglobin or sulfhemoglobin. Whereas it requires about 5 gm of reduced hemoglobin per 100 cc. of blood to cause observable cyanosis, it takes only 1.5 gm of methemoglobin or less than 0.5 gm of sulfhemoglobin to produce cyanosis.¹⁷ In a cyanotic patient without obvious cardiac or pulmonary disease, quantitative measurement of these hemoglobins is indicated.

Methemoglobin results from the oxidation of heme iron from the ferrous to the ferric state and is normally present in erythrocytes in small amounts. In contrast, sulfhemoglobin is never present in normal erythrocytes. Although its exact chemical nature is unknown, it is believed that a sulfur atom replaces one of the nitrogen atoms in the pyrrole ring and disturbs the linkage of heme to the globin, preventing oxygen transport.¹⁸ The formation of sulfhemoglobin is irreversible. Once formed, it remains in the erythrocyte for the life of the cell because there is no intracellular mechanism for reconversion to hemoglobin. The life span of the involved red cells is not shortened by the presence of sulfhemoglobin. Thus, the disappearance of sulfhemoglobin from the blood may take as long as three or four months.¹⁷

Both methemoglobin and sulfhemoglobin are identified by spectrophotometry. Methemoglobin exhibits an absorption band at 630-634 millimicrons, and sulfhemoglobin shows a band at 618-620 millimicrons. Further differentiation can be made by the addition of a few drops of 5% potassium cyanide which dispels the absorption band of methemoglobin but not of sulfhemoglobin.¹⁸

The etiology of sulfhemoglobinemia is incompletely understood. Harrop and Waterfield¹⁹ found that they could produce sulfhemoglobinemia in dogs by feeding them sulfur plus either acetanilid or acetophenetidin. Furthermore, with sulfur and aniline, the dogs developed a combination of methemoglobinemia and sulfhemoglobinemia. These results took several days to occur. When hydrogen sulfide was administered in one large dose, no appreciable amount of sulfhemoglobin was produced. They concluded that the reaction between hemoglobin and hydrogen sulfide to produce sulfhemoglobinemia was slow. They also reported ten cases of patients developing sulfhemoglobinemia following the exposure to aniline-derivatives. Six of the ten gave a history of chronic constipation. These findings supported their hypothesis that sulfhemoglobinemia resulted from ingestion of aniline-derivatives in the presence of sulfur absorbed from the gastrointestinal tract. Presumably constipation increased the amount of absorbed hydrogen sulfide, contributing to the production of sulfhemoglobin. Finch's extensive review¹⁷ lists a number of drugs which have been reported to cause sulfhemoglobinemia including sulfonamide derivatives, phenacetin, acetanilid, and aniline. He concluded that drug-induced sulfhemoglobinemia resulted from an oxidizing drug and either constipation or a sulfur-containing medication. Constipation has not been an invariable finding in previous series.^{20,21} It is not clear why only certain patients taking these drugs develop sulfhemoglobinemia or exactly what role constipation plays, if any.

The patient included in this monograph had spectroscopically proven sulfhemoglobinemia, and after a careful review of all his medications, it was found phenazopyridine to be the only one that was temporally related to the occurrence of the sulfhemoglobinemia. Furthermore, the patient was taking no other drugs known to cause sulfhemoglobinemia. The sulfhemoglobin cleared from his blood over a period of about three months from the time the phenazopyridine was discontinued. This result is consistent with sulfhemoglobinemia, correlating roughly with the average life span of erythrocytes. In addition, he developed mildly elevated levels of methemoglobin. Our patient had been taking phenazopyridine for an extended period of time (26 days). Although we have no definite record of a complaint of constipation, he was treated with three different laxatives after his hospitalization, suggesting a problem with constipation.

Phenazopyridine is almost totally cleared through the kidneys, 40% as the unchanged drug and 50% as aniline and its metabolites.²² We speculate that the administration of phenazopyridine resulted in chronic exposure to its metabolite aniline, which, in the possible presence of constipation, caused production of both sulfhemoglobinemia and methemoglobinemia in our patient. It is interesting in this regard to note that aniline was the only drug that caused both of these heme pigments in the dog studies of Harrop and Waterfield.¹⁹

The treatment of sulfhemoglobinemia is essentially supportive. Reversing its cause, such as by stopping an offending drug, is usually all that is required. Finch¹⁷ believes it to be unlikely that sufficient sulfhemoglobin is ever produced clinically to endanger a patient's life, and we know of no reported deaths from sulfhemoglobinemia. Therefore, exchange transfusions would be rarely, if ever, indicated. Unlike methemoglobin which is rapidly converted to normal hemoglobin by administration of methylene blue, sulfhemoglobin is not converted by any known substance.

How common is phenazopyridine-induced sulfhemoglobinemia? Walton and Lawson²³ in their dog studies produced methemoglobinemia with large doses of phenazopyridine but made no mention of finding any sulfhemoglobin. In 1931 van den Bergh and Revers²⁴ showed that phenazopyridine greatly accelerated sulfhemoglobin formation by hydrogen sulfide *in vitro*. They also reported that in humans phenazopyridine caused a mild degree of sulfhemoglobinemia, and when taken together with magnesium sulphate-containing mineral water, it caused a more severe form. A careful review of the literature, however, reveals a striking absence of any other cases of cyanosis from phenazopyridine-induced sulfhemoglobinemia. In the English literature, we found a total of 14 cases of cyanosis presumed to be caused by phenazopyridine.^{1,2,4-6,8,11-15,25,26} Twelve of the 14 patients had methemoglobinemia documented by spectrophotometry and/or the response to methylene-blue administration. All of these cases occurred in acute overdose situations or in patients with renal insufficiency. The thirteenth case²⁶ was a patient with cyanosis from sulfhemoglobin as determined by spectrophotometry. She had taken Azo-Gastrisin® (a combination of sulfoxazole and phenazopyridine HCl), magnesium sulfate, and phenacetin — containing analgesics. The role of phenazopyridine in causing the sulfhemoglobinemia could not be determined since several other drugs she was taking are

known to cause sulfhemoglobinemia. The fourteenth case¹ involved the chronic use of normally prescribed doses of phenazopyridine in an azotemic patient who developed very low levels of sulfhemoglobin. Her cyanosis was most likely not due to the sulfhemoglobin, however, but rather to her congestive heart failure. Thus, our search of the literature found only one case of possible phenazopyridine-induced sulfhemoglobinemia since van den Bergh's original report in 1931.

We believe that phenazopyridine caused the patient's sulfhemoglobinemia reported in this monograph. Why has this side effect been reported so rarely with such a commonly used drug? There are several possible explanations: 1) It is perhaps an extremely rare occurrence. This is the most likely answer, although van den Bergh's experiments suggest otherwise. 2) Phenazopyridine may cause sulfhemoglobinemia relatively frequently, especially when given chronically, but the sulfhemoglobinemia is so mild that it goes unrecognized. 3) Most therapeutic courses of phenazopyridine are too short to cause sulfhemoglobinemia, which requires an extended amount of time to be produced. 4) Prior cases of cyanosis from phenazopyridine may have been caused by *both* methemoglobin and sulfhemoglobin, but the sulfhemoglobin was not detected because it was not expected or measured. Future investigations will hopefully clarify the answer.

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Summary

The medical history and progress of a patient with cyanosis from sulfhemoglobinemia is reported. It appears to have been caused by administration of phenazopyridine, which has never been reported to cause cyanosis from this abnormal heme pigment.

A discussion of sulfhemoglobinemia is included.

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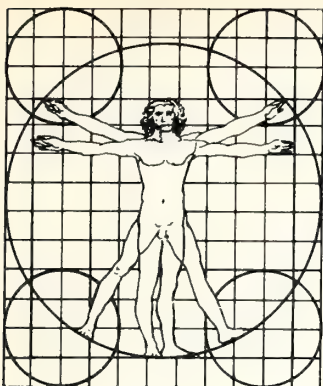
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UPDATE ON APHAKIC CORRECTION — 1983 (YOUR CHOICES AFTER CATARACT SURGERY)

William H. Havener, M.D.

The quality of aphakic correction, formerly with cataract eyeglasses, has been greatly improved by the advent of extended wear contact lenses and by intraocular lens implants. These advances considerably enhance the vision of the 400,000 patients who require cataract surgery annually in the United States.

Phakos is the Greek word for lens. A- is the prefix meaning without. Aphakic is the adjective meaning without a lens. A cataract is a lens that has lost its transparency. Removal of a cataract, therefore, is removal of an imperfect lens. After cataract extraction an eye is *aphakic*; it no longer has its lens and a new lens will not grow back.

You know that a camera has a lens that must be properly focused or the photograph will be out of focus. A camera without a lens cannot produce a clear picture. Similarly, an eye without a lens cannot see a clearly focused picture. After cataract extraction, the *unaided* eye cannot see to read, to recognize friends, or to pass a driver's license test any better than it could before the cataract was removed. An aphakic eye must be focused properly (corrected) with an artificial lens before it can see clearly. The average uncorrected aphakic eye can see only well enough to count fingers at four feet.

Optical correction of an aphakic eye may be achieved in several ways, none of which is perfect. Even when a partial cataract is present, your own natural lens is better than any artificial lens. This means that *an early cataract should not be operated*. The very real but relatively minor handicaps (blur and glare) of an early cataract should be endured because they are less trouble and risk than any of the artificial lenses that can be used. You will be happier if you do not have cataract surgery too soon.

Nevertheless, 400,000 times every year in the United States a cataract becomes so dense and handicapping that the person is better off without it — then it is time for surgery. But what happens after surgery? *Aphakic correction* is the name for what happens next.

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Focusing the operated eye so that it can see (aphakic correction) can be done with a pinhole, with spectacle glasses, with contact lenses, or with intraocular lens implants.

Pinhole

Light passing through a very small opening is focused without any lens at all. This is the principle of a pinhole camera, which takes clear pictures without a lens. If you simply use a small needle to punch a number of tiny holes in a piece of paper, an aphakic eye can look through such a pinhole and see reasonably well. Unfortunately, exact alignment of a tiny pinhole in front of the eye is too troublesome to be a practical method of aphakic correction.

Aphakic Spectacle Lenses

The time-honored and easiest way to see after cataract removal is to wear eyeglasses with the thick lens necessary to focus the aphakic eye. If a modern plastic lens is mounted in a small frame, such glasses can be made to appear reasonably attractive and to be comfortably lightweight. However, they do magnify the appearance of the eye and are recognizably thicker than ordinary eyeglasses. Also, spectacle lenses distort and limit side vision and magnify the view by about 25%. Although magnification is very helpful for reading, it causes trouble in judging distances (such as when walking on steps). If only one eye has been operated, spectacle magnification causes double vision so that the two eyes absolutely *cannot* be used together when wearing aphakic eyeglasses.

If fitted three months after cataract surgery, spectacle eyeglasses often will remain usable for many years. Spectacles are easy to put on and take off, which is a practical consideration for an older person who has had both eyes operated.

Despite some substantial disadvantages, spectacle eyeglasses are still the safest and least expensive way of correcting vision after cataract extraction.

Daily-Wear Contact Lenses

Every morning 12 million nearsighted persons in the United States put in their contact lenses and every evening they take the lenses out. Daily-wear lenses are very effective in providing well-focused eyesight, are reasonably inexpensive, and are quite safe when used with sensible hygienic precautions. Such lenses are equally effective in focusing an eye after cataract surgery. They give good side vision, magnify only 7% (an insignificant amount), and permit both eyes to be used together even though only one has developed a cataract and has been operated.

Older persons do not adapt as well as younger ones to use of contact lenses. Genuine psychologic barriers prevent many older persons from putting a lens upon their eye. Trembling or arthritic hands are incapable of manipulating the tiny lenses. Use of solutions for cleaning and sterilization is an unaccustomed nuisance. Contact lenses can fall out and are lost easily. (Having spare lenses on hand is a simple remedy for loss.)

Many persons are able to use daily-wear contact lenses for aphakic correction and many absolutely cannot do so. If such lenses can be used, they provide vision that is much nearer to normal eyesight than can be provided by cataract spectacles.

Extended-Wear Contact Lenses

The cornea of the eye normally gets its oxygen from the air, not through the lungs. Wearing a daily-wear contact lens slowly suffocates the cornea, which is the reason such a lens must be taken out in the evening to permit overnight recovery of the cornea. In June 1979, the Food and Drug Administration approved the use of a new type of contact lens that is oxygen permeable. The cornea is able to breathe through such an oxygen permeable lens, which is the reason this type of lens can be worn for long periods of time without removal.

The initial promise of these extended wear lenses seemed limitless. Many patients could wear the lens day and night, week after week, even for months at a time. In an ideal case, the lens is completely comfortable and provides excellent eyesight with virtually no bother. The lens is inserted by the professional dispenser and the patient returns for occasional cleaning. Just as a kitchen window, the lens gets dirty after a while and needs cleaning; perhaps every few months.

Originally it was hoped that with a little more technical improvement the extended-wear contact lens would be the nearly perfect answer to aphakic correction. This still may be the case, for substantial improvements in materials and methods continue to develop.

As of 1982, three years after lens approval, the record is that 80% of patients have done very well with extended-wear lenses. A successful wearer who compares use of cataract spectacles with extended wear lenses almost always will state emphatically that the extended-wear lens is much better. Twenty percent of persons do not tolerate the lenses well. Deposits of calcium, protein, or mucous will persistently develop upon lenses worn in some eyes. The lens may not be tolerated and may cause chronic redness and irritation. Preservatives in the lens solutions can cause allergic or toxic reactions. No question about it, some eyes simply do not tolerate extended-wear lenses.

These three years of experience also have shown the lenses to be fragile and subject to loss. On the average, an extended-wear lens requires replacement every six months. Infrequently, some lucky person comes in for a routine check after having worn a lens with complete comfort for more than a year. Sometimes a lens is lost within the first week of fitting. But overall, the average lens breaks, gets cloudy, or is lost every six months. Replacement is expensive, costing several hundred dollars. Routine maintenance and cleaning every few months certainly is much easier than the care for a daily-wear lens.

In perspective, use of an extended-wear contact lens is one of the best available methods for aphakic correction. These lenses are costly. Especially during initial fitting and adjustment, substantial problems of lens tolerance occur in 20% of patients.

Intraocular Lens Implants

Plastic materials such as lucite can be tolerated within the eye. This fact was discovered during World War II when fragments of plastic airplane canopies penetrated aviators' eyes dur-

ing explosions. Since that time, literally dozens and dozens of different shapes of plastic lenses have been designed and inserted into eyes following cataract extraction. Remarkable successes have been achieved, but at the price of many serious complications. By trial and error, lens designs and techniques of insertion have been greatly improved and most of the problems have been eliminated or reduced in frequency and severity to acceptable levels. At the present time, a well-chosen lens implant can be inserted by a skillful surgeon with risks only slightly greater than would occur with cataract surgery done without a lens implant.

One of the nicest lens implant designs is a single-plane posterior chamber lens with flexible loop supports. Let me explain what this means. A single-plane lens is almost flat, in contrast to other types of lenses that are held in place by multiple struts and loops designed to hook and brace the lens in place. (One lens type, made in Russia, had so many little antennae projecting from it in various directions so that it looked like a radio-controlled satellite and was named the "Sputnik.") Posterior chamber refers to the location where the lens is designed to be positioned. The posterior chamber is the space just behind the iris, which is the location of the normal lens of the eye. (Older types of lenses were wedged into the space between the iris and the cornea or were sewed or clipped to the iris.) The supports are the mechanism whereby the lens is held in proper position, lined up optically in the center of the pupil. Flexible loop designates a support made of a very thin curved C-shaped plastic rod extending from the two sides of the lens. These tiny plastic springs press gently against the inside of the eye and automatically center the lens properly. This particular lens is so small as to require only a very short incision through which it enters the eye. When supported in the aqueous fluid inside the eye, this implant is almost weightless. The flexible loops, unlike rigid supporting struts, do not erode the internal eye structures, nor are they likely to cause chronic pain. The lens itself is positioned safely behind the iris, a location from which the lens cannot touch and damage the extremely delicate cells that line the back of the cornea and maintain its transparency.

This particular lens implant type has been in fairly wide use for three years, the same length of time as the extended-wear contact lens. During this time clinical experience has been more free of serious problems than has been true of other types of intraocular lens implants. It does result in two difficulties. The technique of insertion requires the back part of the lens capsule to be preserved. Sometimes this capsule loses its transparency and another operation is necessary to open a window in the capsule. The other problem is called the "sunset syndrome." This refers to a falling downward of the lens so that it is no longer centered in the pupil but is half hidden behind the lower iris, just as the lower half of the setting sun disappears below the horizon. Recentering the lens can be a real problem. Infrequently, a variety of other complications may occur.

Let me emphasize that this is not the only good lens implant. A number of others are equally excellent and even may be preferable under appropriate circumstances.

Not all eyes are suitable for lens implants. In general, the presence of serious eye diseases contraindicate lens implantation. For example, a form of chronic inflammation of the inside of the eye, called uveitis, results in the formation of deposits of pigmented debris upon the surfaces of intraocular structures. Such inflammatory deposits also will smear the surface of an implant, obscuring good vision. Sometimes during surgery the vitreous framework of the eye crowds forward, leaving inadequate space for lens insertion. For this reason, a lens cannot be implanted safely, even though the patient and doctor agreed

before surgery that an implant was the chosen procedure.

Special measurements must be made in advance to determine the proper strength of the lens implant. The goal is to make the eye a little nearsighted, hopefully permitting reading and near work without eyeglasses. There is no possibility of doing without eyeglasses altogether because the accuracy of measurement is not that precise. Also, the artificial lens cannot change its focus, so bifocal glasses usually are required after implant surgery.

The procedure of intraocular lens implantation is technically quite detailed and demanding, requiring a number of special measurements and instruments, as well as the lens which costs several hundred dollars, depending upon the model. As a result, intraocular lens implantation is one of the most costly eye operations. However, with no complications, there is very little post-operative maintenance. This tends to balance costs with the extended-wear lens, which can become quite expensive if you lose or break a lens every six months.

The most recent methods of flexible loop single-plane intraocular lens implantation give results with only about 5% of complications (practically the same as achieved with a standard cataract extraction). Some of these complications may require a second operation, or may rarely be inoperably serious. The visual results are usually as good or better than achieved with extended wear lenses and considerably less maintenance is required.

The initial expense of lens implantation is by far the most costly way of having cataract surgery, but this is gradually recouped because expensive cataract glasses and contact lenses are not necessary. This type of implant ranks as one of the best available methods for aphakic correction.

Final Summary

No method of aphakic correction is free of problems and disadvantages. The circumstances unique to each patient must be evaluated by the ophthalmologist, who then will explain the choices the patient may make, including the choice of postponing surgery upon an early cataract. Sometimes one choice or another is clearly evident. Usually a patient who first learns of the presence of a cataract should allow it to increase in density for a while before it is time for surgery. The speed of development of a cataract handicap is variable and cannot be predicted exactly until after several examinations show the rate of change.

Finally, the methods of aphakic correction continue to change and recommendations almost certainly will be different next year, just as they were different last year.

The purpose of this presentation is to assist patients in making their choice as to what type of optical correction they prefer after cataract surgery, and not to cause apprehension and fear about their cataract care. A cataract is still the nicest cause for loss of vision because in 95% of cases good vision can be restored successfully.

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A medical school's teaching hospitals, in a referral area of 400,000, are seeking a faculty member at the Associate Professor level to have a major role in resident and student teaching, administration and research. Generous salary. Midwest location. Respond to Box No. 4, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

malpractice and hospital insurance paid; other fringe benefits available. Since we are a new group without prior commitments, full participation in the group's corporate structure is anticipated for the correct physician within one year. Call for interview: Mitchell W. Leventhal, M.D., President, Medical Emergency Services, Inc., phone: 216/888-4411 or 831-4095.

EMERGENCY DEPARTMENT PHYSICIANS

Qualified physicians to assist in staffing our Emergency Department on a part-time basis. We are a 70-bed JCAH accredited community hospital located in rural Northern Ohio close to the Lake Erie Islands resort area. Please send current detailed CV to:

Mr. Michael Mericle
Director Ancillary Service
The Bellevue Hospital
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Bellevue, OH 44811

ENT'S, OB/GYN'S, GEN & NEURO & ORTHO SG'S, ANESTHESIOLOGISTS, UROLOGISTS — The Air Force has positions available throughout the United States and overseas. Commissioned grade and pay according to education and experience. In OHIO call 1-513-879-9662 or send resume to Health Professions Recruiting, 1434 N. Broad Street, Fairborn, Ohio 45324.

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FAMILY PRACTICE CLINIC — EASTERN OHIO: Need board eligible/certified family practitioners to join well established medical practice in small eastern Ohio community. Guaranteed, competitive salary and vacation. Contact: Village Medical Clinic, 1814 Enslee Road, Coshocton, Ohio 43812 or call 614/622-7497 after 7:00 P.M.

FAMILY PRACTITIONER: Due to death, immediate opening in established practice for board eligible/certified family

practitioner. OB necessary. Growing northwestern Ohio community of 10,000 with 40,000 service area close to Lake Erie Islands resort area. Please contact:

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GENERAL INTERNISTS AND FAMILY PRACTITIONERS interested in geriatric medicine will find an optimum practice setting in our Sun City, AZ, healthcare centers. CIGNA Healthplan, Inc., one of the nation's largest prepaid health plans, offers an opportunity to practice medicine free of the business aspects. Night and weekend call is very light. Competitive salaries. Excellent benefits. Please respond to: Director, Professional Recruitment, P.O. Box 29030, Phoenix, AZ 85038, (602) 954-3506.

GROUP PRACTICE IN NORTHERN OHIO has opening for general surgeon — board eligible — willing to do small amount of general practice. Small community near large metropolitan areas. Reply to Box No. 915, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

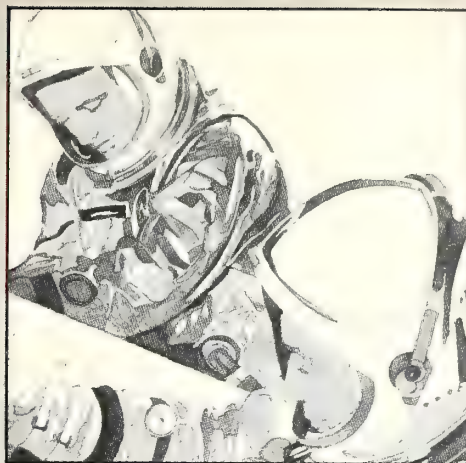
GREAT OPPORTUNITY FOR CARDIOLOGIST OR GROUP OF CARDIOLOGISTS: Clinic with well equipped heart catheterization laboratory and non-invasive cardiac laboratory for lease or rent. Great opportunity for well trained cardiologist(s). Reply to Box No. 1, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

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The Columbus Health Department is seeking a physician (Ohio DO or MD) who wishes to specialize in venereology. Responsibilities include both clinical practice and basic and clinical research, in association with the CDC, Atlanta. Academic affiliation and research involvement are expected. The medical director will receive extensive training in venereology as needed, and will have considerable opportunity for graduate level study. Compensation is open, including an excellent benefit package. This is an exciting position at one of the nation's leading STD clinics. Contact: Peter Parthum, M.D., M.P.H., Medical Director, 181 Washington Blvd., Columbus 43215; 614/222-7367.

Famous Pairs.

The Columbia space shuttle was a triumph of teamwork. And along with Young and Crippen went Anusol-HC Cream to treat prior anorectal conditions aggravated by "G-Force" stresses of exiting and reentering the earth's atmosphere.



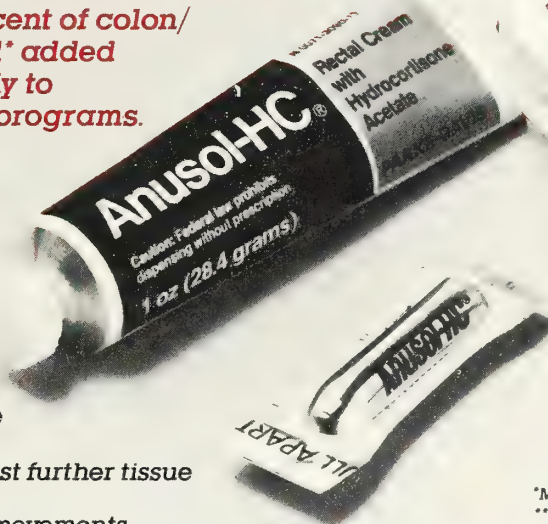
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Suppositories / Cream
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- ☐ Antiinflammatory, to relieve itch, pain, and edema.
- ☐ Astringent, to protect against further tissue damage.
- ☐ Emollient, for easier bowel movements.



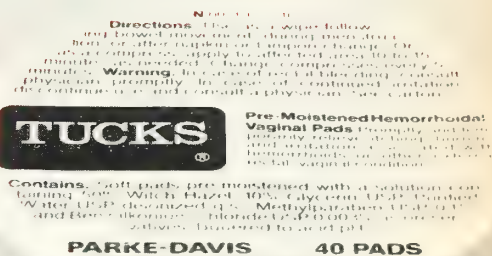
And, when pain is a special problem, Anusol[®] Ointment offers the benefits of the topical anesthetic pramoxine HCl.

TUCKS[®] Pre-Moistened Hemorrhoidal/Vaginal Pads

The #1 hemorrhoidal** pad for added external relief and gentle cleansing.

- ☐ Soothes, cools, comforts, and cleanses irritated anorectal areas.

Once pain and inflammation subside, for dual action recommend regular ANUSOL[®] and TUCKS[®].



Please see opposite page for brief summary of prescribing information.

*Meeting of Am Soc Colon/Rectal Surgeons, May 1980

**Data on file, Marketing Research Dept, Parke-Davis

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TUCKS®

Pre-Moistened Hemorrhoidal/Vaginal Pads

Hemorrhoids and other anorectal uses — TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witch hazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.

Vaginal Uses — Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25% bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0 mg; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy: See "WARNINGS".

Pediatric Use: Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove the tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream — one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 15° - 30° C (59° - 86° F).
1089G010

MULTISPECIALTY GROUP PRACTICE seeking physicians with specialty in: family practice, internal medicine, orthopedics, ENT, radiology, occupational medicine, emergency medicine. Group is undergoing expansion in the fastest growing county in the state of Ohio. Competitive salary and fringe benefits offered. For further information, send CV to:

Medical Director
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Emergency Positions — available with emergency physician group in PA, NY, NJ, VA, WVA, MD, KY, FL, and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to: NEEMA Emergency Medical, Suite 400, 399 Market Street, Philadelphia, PA 19106 or phone 215-925-3511 in PA, or 800-523-0776 outside PA.

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MEDICAL DIRECTOR — Staff model, westside Cleveland based HMO in pre-operational stage is seeking a medical director, prefer board certified. Challenging opportunity to form and manage a pre-paid multispecialty physician staff. Reply to Box No. 995, c/o Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

NORTHEASTERN OHIO EUCLID AREA: Family practice physician to associate next to established busy dental group. No physicians presently practicing in the area. Will remodel office to your specifications. Call Dr. Weil at 238-0770.

OBERLIN, OHIO: 16 person multispecialty group seeks additional family physician. College town with many cultural benefits near Cleveland. Salary leading to equal share in professional corporation after one year. Contact: Dr. VanDyke, 224 W. Lorain St., Oberlin, OH 44074; 216-775-1651.

OB/GYN: Board certified OB/GYN with Ohio license or eligible, interested in establishing a practice in the beautiful Lake Erie Islands resort area. Our rural community has a service of 40,000. Our progressive and modern 70-bed hospital is JCAH accredited. For further information contact: Martin F. Goetze, President, The Bellevue Hospital, Bellevue, Ohio 44811, (419) 483-4040, Extension 200.

OBSTETRICIAN, DERMATOLOGIST, PSYCHIATRIST AND OPHTHALMOLOGIST to locate in rapidly growing North Ridgeville, between Elyria and Cleveland suburb. Population 25,000, drawing area 60,000. None of the above professionals in the area. New professional medical building with 900 square feet suite available for immediate occupancy. Reasonable rates. Contact manager, Midtown Professional-Medical Building, 216-327-7402.

OHIO: PEDIATRICIAN — An extraordinary practice opportunity in general pediatrics. New pediatrics ward planned to open in 1984 with a guaranteed annual salary of \$60,000. Brand new medical office building space available in a community extremely underserved in Pediatrics. Applicant must be board certified or eligible in pediatrics and have a strong commitment to patient care. Send CV to Box No. 999, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

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Cleveland, Milwaukee, Philadelphia.
Full-time and some part-time positions available in quality medical group. Salary and benefits excellent, with profit sharing. No night duty. Malpractice insurance provided. Position also available for area Medical Director. Please send CV to Medac, Inc., Suite 290, 3085 W. Market Street, Akron, Ohio 44313.

PHYSICIAN STAFF OPENING

Well-established OB-GYN needs residency trained family practitioner. Requires well-rounded abilities in office based orthopedics, minor surgery, pediatrics and family medicine. Please send Curriculum vitae to:

Carroll County Women's Clinic, Inc.
Canton Office
120 Dartmouth Ave., S.W.
Canton, Ohio 44710
Phone: 216-454-9011

POSITION OPEN: MEDICAL OPHTHALMOLOGIST WANTED in large midwest practice that is affiliated with university training program. Excellent medical skills required. Knowledge of Argon Laser preferable. Opportunity to assist in surgery and learn YAG Laser available. Salary \$75,000 plus generous benefits and rapid advancement depending on qualifications. Send resume to Box No. 993, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

Equipment

EQUIPMENT WANTED

Small Sandusky business in need of used EKG machines to do exams in homes. Must be in good working order. C. Hartlaub, 803 W. Jefferson, Sandusky, 44870; 419-627-0836.

Position Wanted

PHYSICIAN ASSISTANT: certified looking for position with physician(s) in family practice or internal medicine in Southwestern Ohio. Stephen Zoeler, 530 Deerfield Rd., Lebanon, OH 45036, 513-932-8388.

Practice for Sale

FOR SALE: Well-established (33 years) internal medicine practice in western suburb of Cincinnati. One mile from new hospital. All equipment available. Solo practice. Wish to retire. Reply to Box No. 994, c/o Ohio State Medical Journal, Columbus, Ohio 43215.

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1984 CME CRUISE/CONFERENCES ON LEGAL-MEDICAL ISSUES — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days in Winter, Spring, Summer. Approved for 18-24 CME Cat. 1 credits (AMA/PRA). Distinguished professors. **FLY ROUND TRIP FREE ON CARIBBEAN, MEXICAN, & ALASKAN CRUISES.** Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

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In Case of Emergency...

By Rebecca J. Doll

Few events in life are more frightening to the average person than a medical emergency. The mere sight of blood can send a fullback sinking to the floor. And even the most rational parent will experience bouts of hysteria when a child has been accidentally poisoned.

What do you tell your patients to do in case of emergency? Or perhaps more importantly, what DO your patients DO in case of an emergency? According to a recent Patient Attitude Survey conducted by *Medical Economics* magazine, up to 30% of all adults seek after-hours emergency care in a single year. That's not much different from previous surveys. What is different, however, is where they are getting that care.

In the six years since *Medical Economics'* last Patient Attitude Survey, the proportion of emergency patients bypassing their own physicians, either by choice or because they couldn't reach them, grew from 28 to 39%. Most received care through a hospital emergency room, but an increasing percentage said they received care through an "urgent care center" or found another physician to take care of them. The result? Patient loss for physicians who cannot be reached or who have not provided their patients with clear instructions on what to do in case of a medical emergency.

To be available for after hours emergencies, or to refer — the choice is up to you. However, most respondents said they preferred to be able to reach their physician for personal instructions during an emergency. In fact, "easy telephone access" was listed by 25% of the survey respondents as being extremely

important in terms of satisfaction with their physician and the care they receive. So, if maintaining your relationships with patients is important to you, it would be wise to be available by telephone, or have a colleague cover for you, even if you decide to refer patients for emergency care. An answering service or a "beeper" also helps. But whatever your choice, make certain that your patients know about it. One of the

What do you tell your patients to do in an emergency?

best methods of informing your patients is to develop a patient brochure which instructs your patients on what to do in an emergency, complete with telephone numbers and locations of referral centers.

Pamphlets, listing what to do for emergencies such as cuts, fractures, poisonings, chest pain, burns and animal bites before reaching care, are especially helpful.

So are leaflets listing what should be included in a home first aid kit. And many hospitals print brochures telling patients what to expect in the emergency room. These often are available to private physicians at no charge. You also may want to consider providing your patients with a booklet on first aid.

If you are going to be out of town, make certain to have a colleague cover for you. Your patients are less likely to feel abandoned during a time when they really need you and they're going to appreciate the fact that you are

seeing to their needs when you can't be available.

Try never to keep emergency patients waiting. To a person in pain, an hour's wait can seem like an eternity. Even though this seems like an obvious rule, it is the number one complaint about hospital emergency rooms.

If one were to apply Murphy's Law to medical emergencies, it would be that they always occur in the evening and on the weekends. Many people, especially working mothers, find it helpful if the physician has evening and Saturday morning hours. The availability of evening and weekend hours is one of the most appealing aspects of convenience clinics.

If you decide to have evening and weekend hours, make certain to inform your patients. You can do this via a handout, a notice posted in your reception area or sent with the monthly statement, or by listing hours in the telephone yellow pages.

If you routinely refer patients to an emergency room, telephone them later to make certain they received the care they needed.

Once you've determined a medical emergency care plan for your office, make certain your staff knows about it. Nothing is more irritating to a patient than to feel they are being put off by a staff person, especially in time of crisis. If you have an established plan, your staff can inform the patient of his or her options and help the patient get the care he or she needs. **OSMA**

Rebecca J. Doll is an Associate Executive Director of the OSMA and Director of its Department of Communications.

The benefits

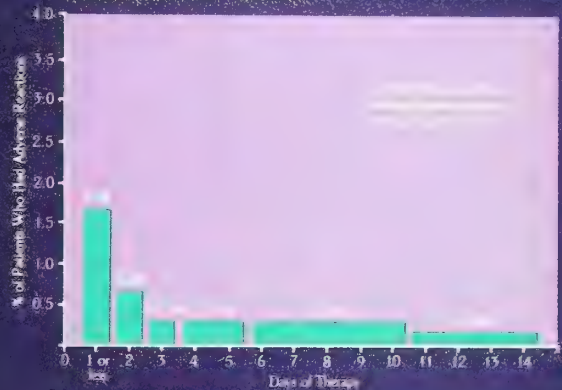
Dalmane (flurazepam HCl/Roche) remains effective yet rarely causes morning hangover

In objective sleep laboratory studies, Dalmane proved more effective than any other hypnotic tested.^{5,6} Patients with insomnia fell asleep 44% sooner on the first three nights of Dalmane therapy and 56% sooner on nights 12 to 14.⁶ Total wake time decreased significantly on the first nights of therapy, and tolerance did not appear to develop for up to 28 consecutive nights of treatment.⁵ Even after four weeks, Dalmane was still significantly more effective than placebo or other hypnotics, some of which lose effectiveness on chronic dosing.^{5,7}

Morning hangover, moreover, was rare with Dalmane. In a study of 2542 patients treated in the hospital, only 3.1% reported adverse reactions after Dalmane treatment. Most of the side effects occurred after the first night of treatment; the incidence diminished as therapy continued.⁸

Caution patients about driving or drinking alcohol during therapy. Because the risks of dizziness, oversedation and ataxia increase with higher dosages in the elderly and debilitated, the dosage should be limited to 15 mg in these patients. Dalmane is contraindicated in pregnancy.

Incidence of adverse reactions



Adapted from Greenblatt *et al*.⁸

And Dalmane (flurazepam HCl/Roche) avoids rebound insomnia

If patients sleep worse when medication is discontinued than they did before treatment began, the value of hypnotic therapy is clearly questionable. Such rebound insomnia has been reported with certain hypnotics that have short half-lives.⁹⁻¹² Yet this problem does not occur with Dalmane as proven in eight of eight sleep laboratory studies.¹¹ Even after two weeks following discontinuation of Dalmane, rebound insomnia had not occurred.⁵

Dalmane. The complete hypnotic that stands apart from all others.



Dalmane®
flurazepam HCl/Roche
15-mg/30-mg capsules

stands apart

References: 1. Data on file. Hoffmann-La Roche Inc., Nutley, NJ. 2. Kaplan SA et al: *J Pharm Sci* 62:1932-1935, Dec 1973. 3. Greenblatt DJ et al: *Clin Pharmacol Ther* 17:1-14, Jan 1975. 4. de Silva JAF, Bekersky I, Puglisi CV: *J Pharm Sci* 63:1837-1841, Dec 1974. 5. Kales A et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 6. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977, and Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 7. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 8. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 9. Kales A, Scharl MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 10. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 11. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 12. Greenblatt DJ et al: *Sleep* 5(Suppl 1):S18-S27, 1982.

Dalmane®
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. Adults: 30 mg usual dosage; 15 mg may suffice in some patients. Elderly or debilitated patients: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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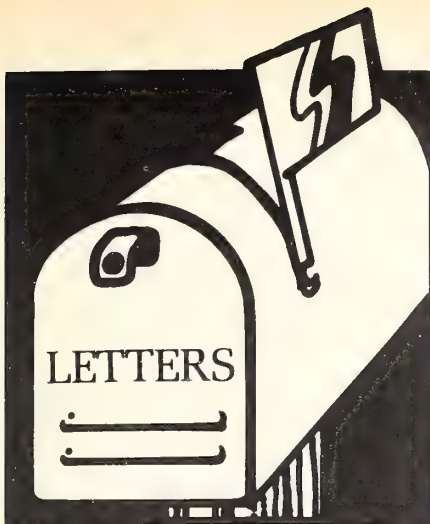
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Letters ... to the editor

Do you have a grievance to air, an opinion you'd like to share? Please send your "Letters to the Editor" and "Second Opinion" articles to: Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Some of both

To the Editor:

I admire the skill with which Robert J. White, MD, presented his views in the essay, "Technocrat or Healer" published in the August, 1983 *Journal*. It seems to me, though, that he has over-simplified the issue, that technology and humanism are not as mutually exclusive as he indicates.

We must recognize that most patients have needs quite different from the selected population Dr. White sees as a professor of neurosurgery in a major teaching institution. A small percentage of people desperately need the kinds of treatment he provides and, for them, issues of technical competence may quite literally be matters of life and death. The great majority, however, are better served by a different balance between knowledge and caring. Doctors who are too preoccupied with disease to understand the people in whom illness occurs may make serious diagnostic and management errors. They also tend to drive the price of health care up by inappropriate use of technology, and sometimes they create public relations problems for the profession by projecting an uncaring image.

It is hardly accurate to accuse those of us who are concerned about this trend of trying to "socialize American medical practice and even subvert its very educational process." I'm proud, though, to plead guilty to Dr. White's charge of believing that some (certainly not all) physicians have "become mesmerized by the new biotechnology and, in the process, (have) lost compassion for and appreciation of the individual patient and family." In my view this is a difficult issue which deserves serious concern by the medical profession. It is not a simple issue of choosing

between the roles of "Technocrat or Healer." The doctor must be some of both.

Sincerely,
Robert D. Gillette, MD
Associate Professor
Department of Family Medicine
University of Cincinnati

Medical school reciprocity

To the Editor:

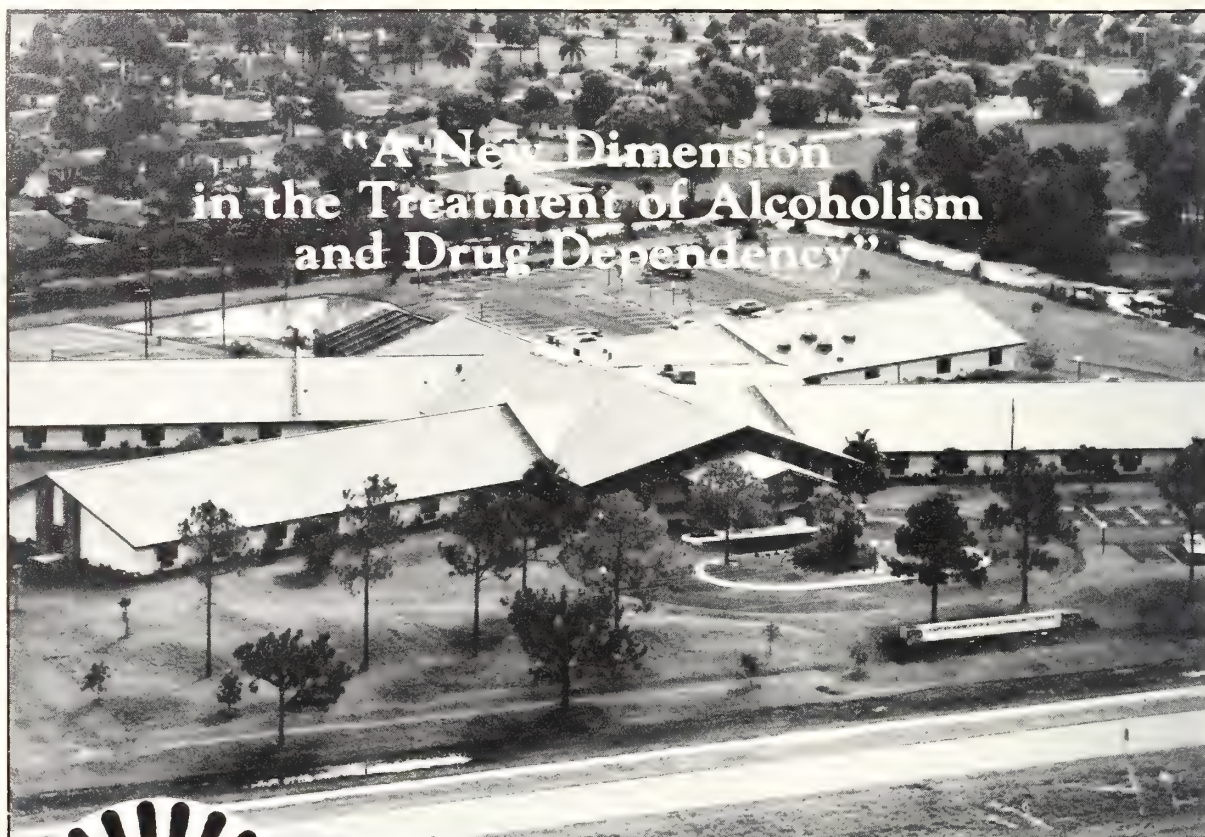
Some years ago, I traveled through Winston-Salem, just a short time after Wake-Forest had been given its beautiful new campus. It struck me as strange, even then, that a roster of its faculty revealed that almost all of its teaching physicians had graduated from Wake-Forest.

Since then (and under the pressure from politicians), it has become almost universal that state medical schools accept students from their own state, at the exclusion of students from outside their state boundaries. "Good!", say the politicians. "After all, our taxes are paying for these medical schools." But is it good when it unnecessarily restricts the educational horizon of our medical students? Wouldn't it be better if the state schools could have reciprocity?

For example, Ohio might accept 10% of its medical students from Indiana, with a corresponding number admitted to Indiana medical schools. Such a system could be easily worked out with a little good will on both sides. It would be to the advantage of our students; improve overall education; widen horizons; provide variety; and keep our future physicians from becoming narrow technicians, which the current restrictions and the shorter periods of studies now favor.

I realize that my proposal is not without its shortcomings. Whatever my medical colleagues might think of it, it is a situation which deserves more thought and more discussion than it has received to date.

Sincerely,
Henry Bachman, MD
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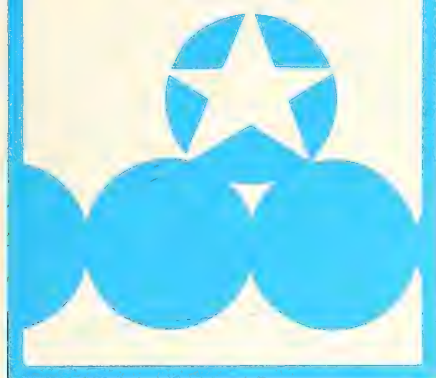
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Colleagues In The News



RASHID ABDU, MD, was recently elected a trustee of St. Elizabeth Hospital Medical Center, Youngstown.

EDWARD H. CHESTER, MD, Solon, recently was reelected to a three-year term on the board of trustees of the American Lung Association of Northern Ohio.

FRANK COX, MD, Rocky River, is the new chairman of the department of internal medicine at Fairview General Hospital.

PATRICIA COOK, MD, Cincinnati, is the new medical director of Mt. Washington Care Center.

JOSEPH FROLKIS, MD, has been appointed coordinator of the newly-created division of general medicine at Mt. Sinai Medical Center, Cleveland.

The Academy of Medicine of Cincinnati recently installed new officers at its annual meeting. They are: **WILLIAM H. GATES, MD**, president; **THOMAS WERNER, MD**, president-elect; **GEORGE HALE, MD**, past president; **KATHRYN WEICHERT, MD**, secretary and **WILLIAM MILLER, MD**, treasurer. Elected trustees were: **RICHARD MEYER, MD**; **JOHN THINNES, MD**; and **WALTER WILDMAN, MD**. New councilmen include: **RONALD FEGELMAN, MD**; **ROBERT HASL, MD**; **WALTER MATERN, MD**; **ERNST ROLFES, MD**; **LEE VESPER, MD**; and **S. MARCUS WIGSER, MD**.

JULIAN GORDON, MD, Cleveland Heights, was elected president of Suburban Community Hospital's Medical Society.

TIBOR J. GREENWALT, MD, Cincinnati, recently was elected to the Institute of Medicine, an extension of the National Academy of Science.

EDWARD HEIN, MD, has been elected to the board of trustees and executive committee of the American Lung Association of Northern Ohio.

STEVEN JOHNSON, MD, was elected President of the Akron Pediatric Society and also recently appointed an assistant clinical professor in pediatrics for the Northeast Ohio College of Medicine. **WAYNE SCHROYER, MD**, Hudson, will serve as vice-president of the Akron Pediatric Society.

KONRAD KIRCHER, MD, is the new president of the Ohio State Radiological Society.

HENRY LEUCHTER, MD, Worthington, has been appointed to a three-year term on the Citizens Advisory Board of the Central Ohio Psychiatric Hospital.

The Cleveland Society of Obstetricians and Gynecologists has elected the following officers for 1984: president, **JOSEPH MARTIN, MD**; **MATTHEW R. BISCOTTI, MD**, secretary; **JEFFREY SEILER, MD**, assistant secretary, **JACOB PALOMAKI, MD**; treasurer, **CHARLES BAILIN, MD**; assistant treasurer, **ROGER HERTZ, MD**; and members-at-large: **GITA GIDWANI, MD**, and **GEORGE GOLER, MD**.

TIMOTHY SCHAEFFER, MD, Westlake, was elected president of the Cleveland Society of Pathologists.



Deirdre O'Connor, MD . . . new Medical Board appointee.

DEIRDRE O'CONNOR, MD, Toledo, recently has been named by Governor Richard Celeste to the Ohio State Medical Board.

SHERRY M. STANLEY, MD, Germantown, recently was appointed director of the Miami Valley Hospital Medical-Surgical Clinic.

DINESH THEKDI, MD, has been named to a three-year term on the board of trustees of the American Heart Association, Northwest Chapter.

S.R. THORWARD, MD, Columbus is the new president of the Central Neuro-Psychiatric Society.

THEODORE EDWARD WYMYSLO, MD, Troy, recently was appointed medical director of the East Dayton Health Center, a joint venture between Miami Valley Hospital, the Wright State University School of Medicine, Montgomery County, the City of Dayton and the combined general health district.

PAUL ZEIT, MD, Burton, was elected to the Board of Trustees of the American Cancer Society, Ohio Division, Inc.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Susan Porter**

Medicine tops list

A survey conducted recently by the National Opinion Research Center at the University of Chicago shows that the public has "a great deal of confidence" in the leaders of the medical profession.

In fact, leaders in medicine ranked tops among 13 social institutions measured in terms of public confidence in their leaderships.

Some 52.5% of the 1,599 people surveyed indicated they had "a great deal of confidence" in the leaders of medicine. That percentage was up from the 45.7% figure recorded in a 1983 survey, but down from a 1974 high of 61.3%.

Confidence in the scientific community ranked second, with a 44.4% rating, also representing an increase over last year's 42.6% but a decline since the all-time high of 50.4% was recorded in 1974.

Public confidence in 10 of the 12 other institutions measured, including banking, education, the media, organized labor and organized religion, was down compared with last year's survey, with many reaching all-time low ratings since the survey was initiated in 1972.

Emergency care

Could it survive a nuclear war?

Prevention is the best medicine, and in no case is this old saying more appropriate than in discussing the possibility of thermonuclear war.

"Emergency health care as we know it will not exist," if such a war should occur, says a position paper published recently by the American College of Emergency Physicians (ACEP). "No organized medical response will be available to meet the acute care needs of the American public."

Extensive damage to transportation and communication networks, along with the destruction of sophisticated hospital facilities would severely curtail efforts by any surviving physicians to extricate, evacuate or treat the injured, the emergency physicians say. "As with other nontreatable diseases, prevention is society's only recourse."

However, those people who do manage to survive the substantial destruction may try to provide emergency care. Therefore, public education should focus on first aid, sanitation and essential survival skills, ACEP concludes.



Hormone may answer cancer questions

Researchers at the Wright State University School of Medicine have discovered a hormone that regulates the production of the white blood cell called granulocytes.

Their findings mark a major step forward in understanding the control of blood cell production and may eventually provide answers to questions surrounding white blood cell disorders such as leukemia.

The investigative team, headed by Takaji Miyake, MD, PhD, formerly of the University of Kumamoto School of Japan, is the first to purify

the hormone erythropoietin which controls red blood cell production.

The Wright State team is now working to purify the newly-discovered hormone which has been named "granulopoietin" or "Gpo" for short.

Purification of Gpo may not only help solve the mystery that surrounds leukemia, but could also aid in the treatment of patients with white blood cell count, reducing their chances for opportunistic infection.

New "fat surgery" not for everyone

Requests for "that new fat surgery" have plastic surgeons throughout the country scrambling to sign up for how-to-do-it continuing medical education courses.

Recently, 400 plastic surgeons learned how to do suction-assisted lipectomy via a live surgery broadcast from UCLA Medical Center. The procedure involves suctioning out small amounts of fat from certain areas of the body to minimize lumps and bumps that haven't responded to diet and exercise.

According to the *Journal of the*

AMA, the procedure usually begins with the surgeon's marking the area to be suctioned while the patient is standing. A half-inch long incision, which can be hidden in a buttock crease or navel is made and a long, hollow cannula, usually between 12 and 13 mm in diameter, is inserted in the incision.

Tunnels of fat are sucked out horizontally through the cannula which is attached to a suction pump pulling at about one atmosphere of pressure. After repeated thrusts of the cannula into the fatty area, a Swiss-

cheese-like pattern is left in the fat. The surgeon pushes down on the remaining fat to collapse the gaps. Bandages keep the gaps from filling with body fluids.

The cost of the procedure ranges from \$750 to \$4,000 and is not reimbursable by insurance. It usually is done under general anesthesia.

According to researchers, the procedure should be reserved for patients whose "bulges have been refractory to diet and exercise. It's not a treatment for obesity."

Medical school enrollments decline

For the first time in 17 years, the enrollment of first-year medical students has decreased, according to a recent report in the *Journal of the American Medical Association (JAMA)*. Also, the number of medical school applicants in 1982-83 was down by 1,000 compared to the previous year, representing a 2.7% decrease and indicating a trend that is likely to continue throughout the decade.

Reasons given for the decline include cutbacks of medical school subsidies by states, plus the fact that some medical schools are switching from three- to four-year programs. Another factor is that there simply are fewer 22-year-olds in the population, the authors of the report say.

Overall, however, the number of students in U.S. medical schools is up by over 1% over last year, the report indicates. Some 66,886 medical students were enrolled in 127 medical schools during the 1982-83 academic year.

The report also indicates higher numbers of women medical students enrolled, with a 1.4% increase over the previous school year; women now represent 29.3% of total students enrolled. No gains, however, were seen among minorities.

Chances of getting into medical school remained relatively constant, despite the dwindling enrollment

numbers. For every 2.1 applicants, one was accepted, according to the report.

In addition, the report shows that 75% of entering medical students were residents of the state in which

the school was located. In medical schools termed "wholly public," 90% of the students were state residents, while only 50% attending privately-supported schools lived within the state.



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On Record

Editor's note: David Jackson, MD, is the new director of the Ohio Department of Health. In order to introduce him to our readers, we engaged him in a dialogue in which he expands his views of state policy, changes in the health care system . . . and the controversial moratorium on the expansion of health care facilities.

David Jackson, MD

Maintaining a Dialogue

By Carol Wright Mullinax

THE OHIO STATE MEDICAL JOURNAL: As the director of health, how would you describe your role in forming state policy?

DAVID JACKSON, MD: To be an effective director of health — as any large program manager with a number of regulatory and policy issues — you have to be able to know how to get people to work together and how to define areas of agreement. If I had to assess my strengths and weaknesses, one of my strengths is getting people together and defining where they agree and working from there, rather than getting bogged down early with disagreements. When you find there is 90% agreement, it is a lot easier to negotiate that last 10% in a reasonable and prudent way.

I think you have to recognize that the department doesn't have all the expertise in the world. Certainly the director doesn't have all the expertise in the world. It is very much like a clinical decision. If you are going to be an intensive care physician — and I think I was a pretty good one — you have to know what you know and what you don't know. You have to know when to ask for help and you have to know how to synthesize the often divergent suggestions of your

colleagues into some reasonable plan. You have to be flexible and you have to reassess.

JOURNAL: What about the public's perception of the health department? Most people think of public health, environmental health, immunizations, and health education, but lately there seems to be more talk of health care financing. Is the role of the health department changing?

DR. JACKSON: Clearly, the department has many traditional strengths in the health arena — planning, maternal and child health, preventive health and environmental health.

Traditionally, it has not been involved in the debates in Medicaid policies or in cost containment issues — beyond capital cost under the Certificate of Need process.

There is no economic analysis expertise in the Department of Health on health finance issues. Part of the problem with the Certificate of Need system is that the projections of the economic impact of project "X" have essentially been taken at face value without any analysis because the department didn't have that ability. We have never held the proposers accountable for their projections.



David Jackson, MD

The strengths of the American health care system have to be protected — but we must face up to the need for real, substantive changes. We can't just twiddle at the margins.

But people in the health care field are now beginning to realize that you will be held to what you say in a Certificate of Need proposal. That makes better Certificate of Need proposals. It means my job is going to be easier because I don't have to deal with people playing games with numbers. People should know that if they underestimate the cost, it is to their disadvantage. One of the things the moratorium will allow is a full discussion of how the system should operate so we will all have the same ground rules when it starts up again.

JOURNAL: Did you bring with you any personal philosophy toward health care which influences the way you handle the job as director of health?

DR. JACKSON: I think we are all creatures of our experiences. I come to public policy shaped by two things. One is my family. When I said a little over 30 years ago that I wanted to go to medical school and be a doctor they said, "that's fine; it is a noble profession. But understand that the most important of all professional ambitions is public service." How you define that in your life's work is obviously an individual thing, but activity in public policy issues is an important and central part of it.

The second factor that shaped me is what happened as I learned to be a physician. I think I will always carry the importance of the doctor-patient relationship with me.

The strengths of the American health care system have to be protected — but we must face up to the need for very real and substantive changes; we can't just twiddle at the margins.

JOURNAL: What kinds of substantive changes in the health care system do you foresee?

DR. JACKSON: I think we have to stop paying lip service to preventive health and health promotion and start making it a reality. That means better educational programs in the grade schools, programs on the dangers of alcohol and drug abuse — coming to

grips as a society with the real costs and benefits (if you will) of tobacco use. We have to understand that there are a number of lifestyle choices that we make as individuals without a clear understanding of the long-term implications. Without being preachy, we have to make people understand the choices they are making and the implications of them.

I think that in the direct care delivery service, we need to do something about the medically underserved population in this state and in the nation — programs like the National Health Service Corp. There are 62 physicians in the state under that program that are sited in various designated underserved areas. But that's a one- or two-year doc. Although that's better than none, we have to look at the structural reasons of why doctors aren't choosing to locate their practices in those areas — and provide incentives for them to do so — economic quality of life and security incentives. I am a firm believer in providing initiatives and incentives in the system and letting the system work. Regulation should be a last resort — to use when it is clear that the system operating by its own set of forces doesn't work effectively.

That gets us to one of the central issues that I've discussed with the OSMA. We share a philosophical belief that the government's regulatory process should not at this time be expanded into the capital allocation for private and group physician offices. I am supportive of the intent of the law and the philosophy behind it — that it would be the intrusion of the government regulatory tentacles into areas where history would suggest they should not be. But there is another side to that coin. We can't distort the definition of a doctor's office to include things that are by most individuals' perceptions health care facilities, and just use the blanket rubric that if it is a doctor's office you can't regulate it. We have to protect the valid physician's office and the group practices' offices. But there are

also situations where you cluster a few doctors' offices around an ambulatory surgery center and try to call the whole thing a doctor's office when the law says ambulatory surgery centers are health care facilities. I'm not going to allow that kind of game playing and distortion. It threatens the very roots of the philosophical agreement that we share about the fact that doctors' offices by any kind of reasonable, rational definition are not a reviewable issue. And yet, the more you stretch it beyond recognition, the more likely the response is going to be: "Well, we can't make the distinction between what is a doctor's office and what isn't a doctor's office." What Georgia has done is said if you won't help us make that distinction, then we'll review everything. I think that would be counterproductive and a mistake. I think we need to make the distinction between a facility and an office. And I think we can make it.

I think good people of good will can sit down and make objective criteria that will allow for reasonable distinctions to be made. There will always be the fine line, no matter where you draw it. Common sense will have to dictate how you deal with that small number. But the bulk of them will clearly fall in one area or the other.

JOURNAL: What about the moratorium?

DR. JACKSON: The moratorium came out of three weeks of grappling with the issues and going to the last meeting of Phase One on the Governor's Health Cost Commission. While there, I said, "I've changed my mind. I think we need to take the opportunity to take another look at the whole Certificate of Need system." I had initially not been in support of the concept of the moratorium. But I thought if we could show some positive aspects that it would be less than a year; that it would be phased out as soon as criteria were available; that we would provide exemptions so that prudent and necessary things could be accomplished during the

moratorium; and that we would be fair about things already in the pipeline. We were hoping to show that we could use the moratorium as an opportunity to do some really exciting things.

We were very fortunate in the Governor's Commission to have superb representatives from all the major professional groups. Dr. Ross Irons has made very, very major contributions to the dialogue. And the representatives from the hospital association have been very productive.

There was a sense in that commission that change was going to happen. The issue wasn't how can we stop it; it was how can we shape it.

JOURNAL: The *OSMA Journal* is a perfect forum for you to reach Ohio physicians. Is there anything which you would specifically like to address?

DR. JACKSON: The message I want to carry to all groups, but particularly my colleagues, is: the 1980s are probably the time of the most profound changes in the health care system — at least in the administrative aspects. How that system emerges from this time of dramatic issues and dramatic change depends to a large degree on the quality of the dialogue that goes into the shaping of that change. Physicians, like all interested groups, have to become thoughtful, articulate, involved members of this dialogue. No longer can we think the political process is something we leave to our lobbyists — if we don't articulate how we see the system, then we don't have any right to object to what is being done.

Carol Wright Mullinax is Associate Director, Department of Communications.

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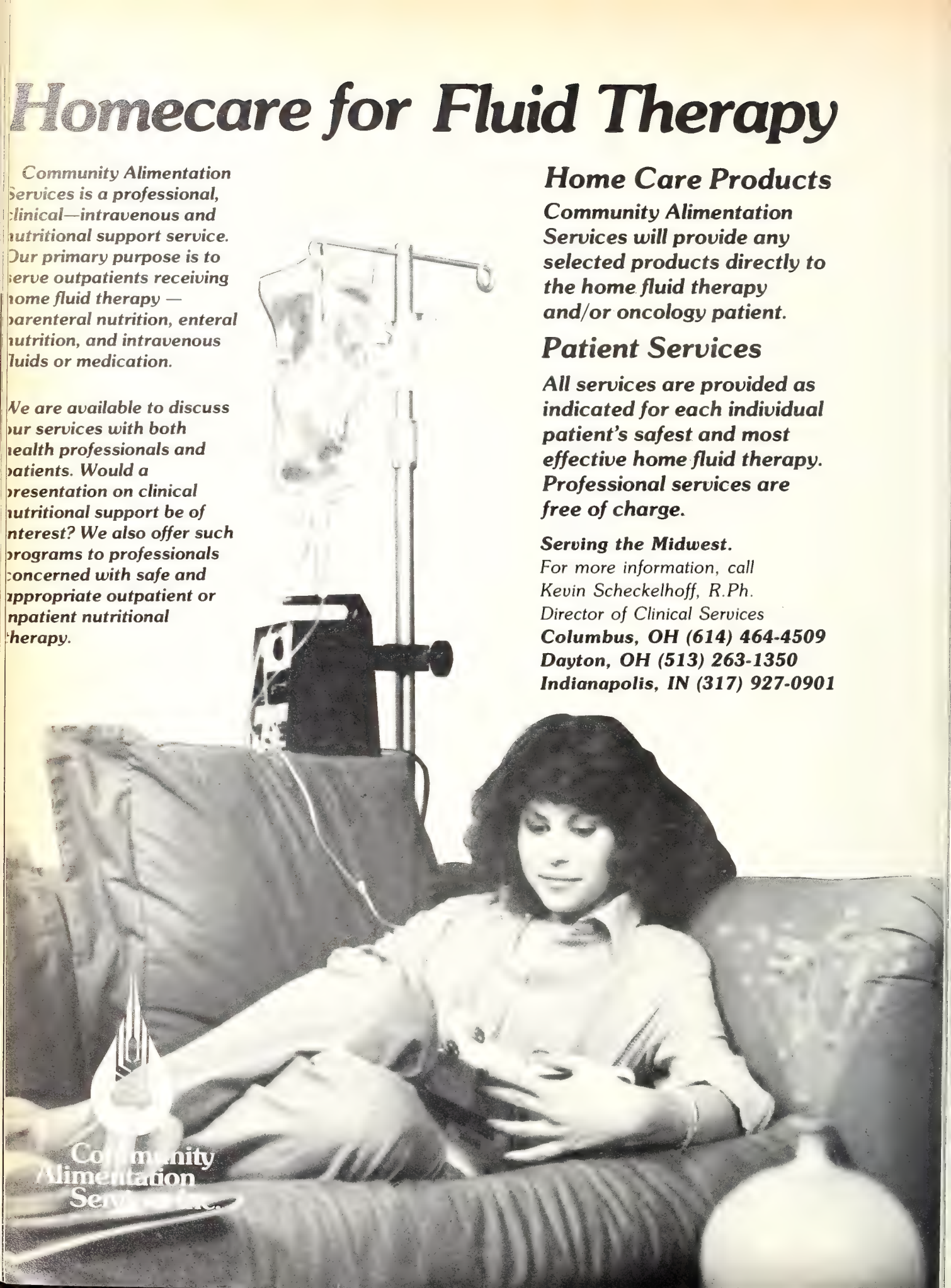
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Ohio's Medical Schools Compared to Other States: Size and Cost

By Stephen E. Peterson, PhD
Alvin E. Rodin, MD

Recent pronouncements by the Ohio Board of Regents (OBR) have focused dramatic attention on the state's seven medical schools and the supply of practicing Ohio physicians. The OBR believes that Ohio medical schools are producing many more physicians than the number that will be needed to meet future needs, and recommends reducing the number of first-year positions by approximately 50%. Three alternative solutions have been proposed: proportional reduction in class size for all seven medical schools, reconfiguration of the existing schools, and phase out of the three new schools.

Ohio Physician Supply

The number of medical schools in the state increased dramatically with the addition of three new medical schools in the last decade. Schools and the number of first-year positions in each are depicted in Table One. The productivity of this system or the effect on total physician supply will not be felt until the medical education pipeline (four years of medical school plus three to five years of residency) produces as many graduates as first-year enrollees.

In 1983 Ohio medical schools

graduated 725 physicians. This number will grow to approximately 1,026 when all schools have reached full complement graduating class size. In 1975, it was estimated that there were 5,422 primary care physicians (general practitioners, general internists, obstetrician-gynecologists, and pediatricians) practicing in the state.¹ By 1995, this is projected to be 8,131; an increase from 50.3 to 74.0 primary care physicians per 100,000 population.¹

**The most recent
data available on
the retention of
Ohio medical
school graduates
appears unalarming
— despite concerns
to the contrary . . .**

Between 1975 and 1980, the total number of physicians increased from 11,918 to 16,241, a net increase of 4,323 (36%).² Despite this significant

increase in the number of physicians, Ohio's ratio of one physician per 665 persons in the population remains significantly below the national average of one physician per 560 population.²

One factor in the supply of practicing physicians is retention. The most recent data available on the retention of Ohio medical school graduates appears unalarming, despite concerns to the contrary by the OBR. Between 1977 and 1981, retention increased from 50% to 55.2%, which approximates the national average.² Although Ohio contributes its share of physicians to other states, it probably has received more than its share in the past from other sources (states and foreign countries). In 1980, 75.5% of the practicing physician supply came from outside Ohio (51.6% from other states and 13.9% from other countries).²

For many years, Ohio has been dependent upon its own residency programs as a source of physicians to expand and replenish the physician supply. Many of these residency programs have been filled by foreign medical graduates and United States medical graduates from other states.

continued on page 825

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Ohio's Medical Schools Compared

continued

In 1977, Ohio, along with 15 other states, was a net importer of American medical school graduates.³ That is, more residency positions were filled in the state by graduates of United States medical schools than there were medical school graduates in the state. (Recent data on the state's status is not available, but with recent increases in the number of medical school graduates, Ohio may no longer fall into this category.)

Ohio Medical Education Costs

A comparison of how Ohio ranks in dollar support of medical student education is provided in Table Two. Ohio ranks fifth in support per state resident behind Texas, Michigan, Illinois, and California, listed in rank order. In 1979, the amount of state funds paid to Ohio public schools and Case Western Reserve University equaled \$48.8 million and averaged \$4.55 per state resident compared to a national average of \$5.07.⁴ For every \$10,000 in personal income, Ohio citizens paid \$5.19 to support undergraduate medical education while the national average was \$5.85.⁴

In 1981-82, the state of Ohio had 879 entering students, the sixth largest number of any state (Table Three). In comparison to other states, Ohio had 8.2 entering students per 100,000 population while the national average was 7.3.⁵ Eleven states ranked ahead of Ohio on this measure — South Dakota, Nebraska, New York, North Dakota, Kansas, Minnesota, District of Columbia, Vermont, Hawaii, Maryland, and Louisiana, which are listed in rank order.⁵

Although Ohio's first-year enrollment has expanded since 1981-82 to 1,026 in 1983, other states have expanded too. In 1981, the per capita income for the state was \$10,371 compared to a national average of \$10,517, giving Ohio a ranking of twenty-fourth amongst the states. Thus Ohio ranks higher in the number of entering students per 100,000 population (twelfth) and in per capita support of higher education (fifth) than it does in affluence (twenty-fourth).

Table One:

Number of First-Year Positions in Ohio
Osteopathic and Allopathic Medical Schools

Schools	First-Year Positions
Case Western University	145
University of Cincinnati	198
Northeastern Ohio University	100
Ohio State University	233
Ohio University	100
Medical College of Ohio at Toledo	150
Wright State University	100
	1026

Table Two:

State Funds in Support of Public and Private
Medical Schools Located in the State, 1979*

State	Support for Public and Private Schools in Thousands	Support Per State Resident	
	of Dollars	Dollars	Ranking
Texas	140,983	10.81	1
California	102,704	4.60	4
Illinois	55,148	4.91	3
Ohio	48,835	4.55	5
Michigan	48,490	5.28	2

*Abstracted from: State Funds in Support of Public and Private Medical Schools, 1979. J Med Educ 55:885-887, 1980.

The Graduate Medical Education National Advisory Committee (GMENAC) predicts that there will be a surplus of 70,000 physicians in 1990,⁶ although this estimate is seriously questioned.⁷ In comparison to other states, Ohio will contribute more to this surplus in relation to its size and affluence than most other states. Even though there may be an aggregate physician surplus in 1990, GMENAC expects specialty and geographic maldistribution to persist. Physician shortages are expected to exist in some rural and urban areas and in some specialties such as child psychiatry, emergency medicine, preventive medicine and adult psychiatry.

A 1980 study reported that between 1960 and 1977, percentage increases in specialist to population ratios in small towns significantly exceeded that in metropolitan areas.⁸ Two explanations seem plausible for this finding. The increased supply of specialists may have activated the market forces of supply and demand and a new preference for small town living may have evolved.

Implications

If no adjustments are made in the entering class sizes today, eventually the market forces of supply and demand might begin to take effect. Physicians could begin to "spill over"

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Ohio's Medical Schools Compared

continued

into the medically underserved areas and gravitate to the shortage specialties.

Total reliance upon supply and demand, however, to solve the physician manpower dilemma would be too costly in terms of public dollars spent on medical student education and private dollars spent on health care. Physicians, like attorneys and other professionals, have the ability to create a need for their services, inhibiting the interplay of supply and demand. This could result in more over-diagnosing, over-prescribing, over-treating and iatrogenic diseases (physician induced illnesses).

Each physician can be expected to generate a given level of health care costs, estimated by the former HEW to be in excess of \$250,000 in 1980. The cost of educating medical students is so great that we cannot afford to train physicians who may never be needed.

In some states, enrollment reductions are already being considered. The number of first-year positions in Michigan medical schools may be decreased by 14% for the 1982-83 school year.⁹ The enrollment cut is seen as a way to compensate for less state support and the expiration of federal capitation grants as well as a response to the perception that excess physicians may contribute to rising health care costs. There is some question, however, whether reduced class sizes would significantly reduce costs.

Some factions are in favor of increasing tuition costs until it becomes a factor in limiting the number of applicants. Many medical schools in economically depressed midwestern states such as Ohio have already increased tuition rates. As tuition rates increase and the availability of federally supported student loans decreases, academic and non-academic characteristics of the entering classes may change.¹⁰ Fewer and fewer minority students would be able to afford the cost of a medical education. Thus escalating tuition

Table Three:
Ranking of States by Number of State Residents
Entering Medical School Per 100,000 Population*

State	Entering Students		Per 100,000 Population	
	No.	Rank	No.	Rank
South Dakota	80	39	11.8	1
Nebraska	176	30	11.2	2
New York	1925	1	11.0	3
North Dakota	68	41	10.5	4
Kansas	236	24	10.0	5
Minnesota	372	12	9.1	6
District of Columbia	56	42	9.0	7
Vermont	46	45	8.9	8
Hawaii	79	40	8.5	9
Maryland	359	13	8.5	9
Louisiana	355	14	8.3	11
Ohio	879	6	8.2	12

*Abstracted from: Crowley, AE; Medical Education in the United States 1981-1982. JAMA 248:3223-3317, 1982.

costs would reverse many of the recent social accomplishments in minority education.

Most attempts at manpower planning have been interpreted too specifically concerning the state of the art. The Ohio Department of Health forecasting model,¹ which forecasted an increase in physician supply, assumed that the retention and migration rates in Ohio will remain constant. This assumption may be invalidated by the severe recession effecting midwestern industrial states such as Ohio in the past two years.

Young physicians may have an even greater attraction to the sunbelt areas where the economic picture is much brighter. Also, as hospitals are caught in the economic crunch caused by changes in medicare reimbursement, reductions in the number of residency positions offered seems probable. Thus, the state could have greater difficulty retaining students and attracting students from other states for residency training.

Retention rates may also change with the addition of graduates from the state's three new schools. They may be influenced by better practice

opportunities in states with better economies than that of Ohio.

The forecasting model also assumes that physician productivity will remain constant in future years. With greater physician supply, however, it seems probable that physicians would work fewer hours per week than in the past.

Finally, more and more women are being admitted to medical school today than in the past. Therefore, projections will only be accurate if they include the fact that women work less hours per week and less weeks per year than men. These are only a few of the variables that make physician manpower planning a very difficult task at best.

Summary

In summary, in spite of increase in the number of medical schools in Ohio, the physician to population ratio is less than the average for all states. In the past, the history of physician manpower planning has been spotted with periods of expansion and reductionism. It will always be necessary to make periodic adjustments in the total physician supply. With minimal tampering of

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Ohio's Medical Schools Compared

continued

the medical education system already in place, the state will be in a good position to increase enrollment at little cost in the next period of expansionism which seems improbable today but is certain to follow. **OSMA**

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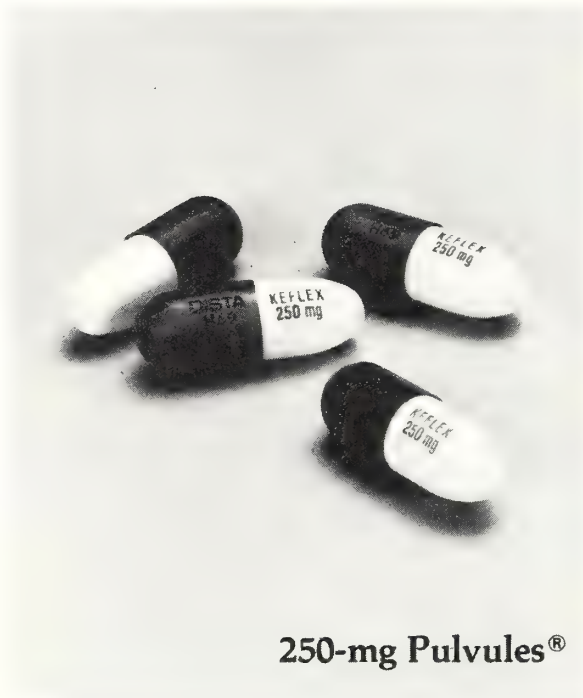
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The DRGs . . . Have Arrived!

By Karen S. Edwards
and Susan Porter

Diagnostic Related Groups (DRGs), the government's new method to reduce the stress on Medicare, isn't just around the corner anymore. The system has been in effect since early October, and hospitals and physicians are doing what they can to smooth the way for its implementation — but it's a system that's going to take some time to understand.

This past September, the Ohio State Medical Association, in cooperation with its Committee on Cost Effectiveness, and the Ohio Hospital Association sponsored a seminar entitled "DRGs, Charting the Course" in which both the physician and hospital views on this new system were examined.

What follows is a look at these views and at the eventual impact the DRG system may have on medicine in this country.

* * *

Referring to DRGs as "the single most important piece of legislation to be passed in my lifetime," Thomas Gretter, MD, Quality Assurance Officer for the Cleveland Clinic, stresses that physicians are going to have to know the rules of the game, even though DRGs are — at least now — primarily the hospital's concern.

"On the positive side of this, physicians are going to have greater access to cost data which has been unavailable to them in the past," Dr. Gretter continues, adding that most physicians are generally not aware of what many of the procedures and tests they order actually cost.

"I don't know of a single physician whose goal is to run up the hospital bill. I think physicians will welcome the opportunity to treat patients in a more cost effective manner."

But, he warns, this will mean an increasing emphasis in the accuracy of medical records, and in diagnosing.

"Medical records will improve, and I can see a whole new class of experts in this area being created."

On the more negative side, Dr. Gretter mentions that DRGs fail to take into account the severity of an illness.

"Physicians are still going to have to take responsibility for the quality of care delivered," Dr. Gretter says.

The DRG system, for example, does not allow for the patient who is admitted for an appendectomy, but suffers a myocardial infarction while he or she is recovering.

"And the fact that there is a lack of skilled nursing beds creates another problem," Dr. Gretter says. "Under the DRG system, patients have to be released in a certain number of days. But where are they going to go once they're released?"

It's important that the alignment between the hospital's medical staff and its administrative staff be maintained, Dr. Gretter emphasizes.

"Physicians are going to have to care for their patients the best way they know how," he says, "and the hospital's responsibility will be to make sure that the care is delivered in the most cost efficient manner possible."

There's little doubt, however, that peer review organizations (PROs) are likely to spring up under the new system.

"They will reduce things like unnecessary, invasive surgery, and outpatient surgery. I think most physicians understand the need for them, but we can't help but be a bit resentful, too," Dr. Gretter says. "The PROs are obviously designed to prevent cheating, and I don't like the implication that our decisions can't be trusted."

What strategy should physicians use in the future, now that DRGs are here?

"We need to continue practicing high-quality medicine and keep an eye out for information on patterns of care. But we must also be willing to cooperate as fully as possible with hospital administrators during this period of DRG implementation."

* * *

Hospital administrators also must do their part to work cooperatively with the medical staff during implementation of the DRG system. "Without the physicians, the hospitals would be nothing," said Daniel G. Wood, vice-president and treasurer of Good Samaritan Hospital in Cincinnati, who delivered "The

Hospital's Point of View" in the DRG seminar.

Likewise, physicians depend upon hospital facilities and support staff to carry out their professions, Wood said. Thus cooperation between the two groups is crucial, particularly during this phase-in period of the DRG system.

Although the new law became effective October 1, 1983, hospitals will not be reimbursed according to the DRG system until the start of their next fiscal year. For most Ohio hospitals, the fiscal year begins January 1. Others will not have to worry about DRGs until next July.

Wood gave a detailed description of how hospital recordkeeping will have to change in order to accommodate the DRG system. James S. Todd, MD, Ridgewood, New Jersey, and an AMA Board of Trustees member, estimated hospitals will spend between \$200,000 and \$300,000 in "tooling up" for the system, including acquisition of appropriate data processing systems and personnel.

While the old method reimbursed hospitals for Medicare patients according to cost, the DRG system reimburses them according to category. This gives hospitals two incentives, Wood said. The first is to reduce the cost of each inpatient's stay, which has implications for the quality of care delivered. The second is to increase the number of inpatient admissions, thus increasing competition among hospitals.

The DRG system could remove the incentive for improved high-cost technology, according to Wood, because hospital budgets may no longer be able to absorb expensive equipment purchases. The system may also tempt hospitals to "close out" services which have been assigned low DRG figures.

In spite of potential drawbacks, DRGs offer hospital administrators a vehicle for sitting down with their physicians and reviewing individual cases, as well as their services as a whole. As intended, it also forces hospitals and physicians to be more cost-conscious in their practices.

"We can look at it like a glass of water," Wood concluded, "and say it's either half empty or half full." **OSMA**

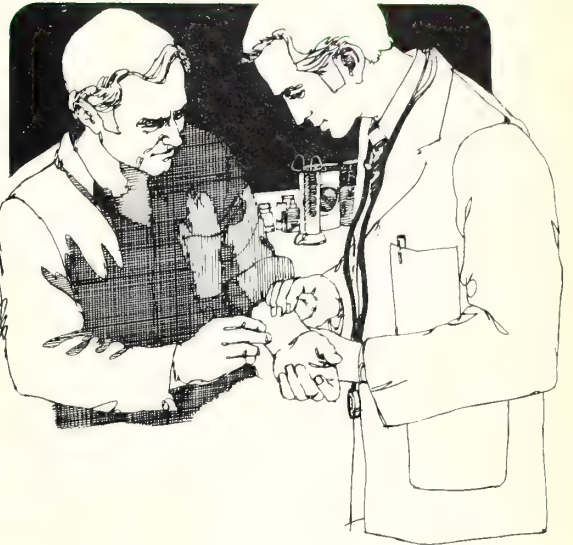


Reducing the Pressure

Health care for the unemployed

For the past six months, the state's unemployed have had a healthier time of it, thanks to special health care programs set up by the county medical societies. Will the programs continue? "You bet," they say . . . and here's why.

By Susan Porter



A Columbus man with an injured hand waited four days to seek treatment because he had no job, no insurance, and no way to pay for a trip to the emergency room or a visit with his physician. A call to "Project Health Concern" got him the medical attention he needed for several broken fingers.

In Cleveland, a middle-aged woman ignored acute chest pains because she recently had lost her job and her health care coverage. Finally, she learned about "Project 83" and shortly thereafter was admitted to a local hospital where she underwent triple by-pass open heart surgery.

A Sandusky man with no income was in critical need of renal dialysis. "Project Health Concern" there made the arrangements necessary for him to get it.

In Massillon, a laid-off construction worker ran up a \$6,000 hospital bill following a vehicular accident last April. "MCH Medi-Share" took care of it for him.

In Toledo it's called "Academy Med-Assist." In Dayton it's known as "Project-MEND." In Akron it's "Project Summit." And in Youngstown, it has no formal name, although its purpose is the same — to aid those who have lost their jobs and subsequently their health care benefits get the medical attention they need before emergencies like the above occur, as well as after.

"These are people who own their own homes, their own cars, and therefore are not eligible for programs like Medicaid," says James Barnes, MD, past president of the Academy of Medicine of Columbus and Franklin County and the director of "Project Health Concern." "Ordinarily, they would be paying their own physicians, but they can't afford to, so they're just not going, or they're waiting too long."

As in similar programs throughout the state, "Project Health Concern" is aimed at the victims of the recession, or those who, until recently, enjoyed not only good incomes but exceptional health care benefit packages. Today, they not only are out of work, but they also are out of the funds they need to cover the hefty premium of an individual health insurance policy, not to mention the full cost of regular or emergency medical care.

In response to this problem, the Ohio State Medical Association (OSMA) Council voted last December to "encourage the development of an effort to provide free or reduced cost health care to those of our neighbors who currently are unemployed, uninsured and ineligible for Medicaid or other existing assistance programs," according to C. Douglass Ford, MD. Dr. Ford, then president of the OSMA, issued a state-wide call to county medical societies to set up programs at the local level, thus

permitting "the matching of the resources in the county with your unique problems."

Since his letter went out December 20, 1982, nearly every medical society in the state has at least discussed the issue, with many requesting help from the OSMA in developing full-scale programs to solve the problem in their communities.

The Trumbull County Medical Society in Warren, Ohio, for instance, has set up a special clinic at the Trumbull Memorial Hospital one day per week for unemployed patients and their dependents who have no regular physician and no means of paying one. Those who have a family doctor are urged to continue seeing him or her. "No one (of us) signed up for a formal program," says Lewis P. Sarkos, MD, then president of the Trumbull County Medical Society. "It was a matter of a verbal consensus among society members that we would continue to see our patients."

No formal program has been established in Cincinnati either, although a coalition of local organizations, including the Cincinnati Academy of Medicine, and the AFL-CIO are working together to see what more can be done to help the medically indigent.

"Cincinnati is unique in that we have 14 health clinics in the area which routinely care for the unemployed, and others with little or

no income," says William Galligan, Executive Director of the Cincinnati Academy of Medicine.

"Private physicians are continuing to see their patients, but a telephone hotline has recently been established to help those who may not be receiving care."

As Galligan explains it, callers will first be asked to contact their family physician, and the Academy will serve as a liaison between the caller and the physician, if that's desired. If the caller has no physician, then he or she will be referred to one of the clinics.

"We have no hard data on what the community's needs are," Galligan says. "At this point, we're still feeling our way along."

In Huron County, society members voted unanimously "in favor of helping the temporarily or newly unemployed, but to continue doing so by our present methods," according to a letter issued by Theodore R. Ball, MD, president of the Huron County Medical Society. "... (We) have always allowed for personal problems of a financial nature when dealing with our patients. Small town physicians are aware of patients' problems in almost every instance."

Yet in even smaller Ashland County, over half the doctors are involved in a special program set up jointly by the medical society and the local Salvation Army, according to Robert B. Davis, MD, in charge of the project for the Ashland County Medical Society. Pharmacists, a local hospital, and a Columbus lab also are involved in that program which was started July 1 and, to date, "is working fairly well," according to Dr. Davis.

The Erie County Medical Society in Sandusky is another small county to successfully implement a health care program for the unemployed; as in Ashland, a community-wide approach has been taken.

"We set up our program June 1, and at that time we were the smallest county to organize one," says Robert J. Ailes, MD, chairman of "Project Health Concern" there. The program is administered with the help of Providence Hospital in Sandusky, which not only provides free hospitalization to eligible patients but also screens calls, makes appointments and provides nursing personnel for two free clinics held there weekly.

"They've bent over backwards to help us," Dr. Ailes comments. "We couldn't have done it without them."

A community-wide approach also has been taken in the larger cities which have sponsored programs. The Academy of Medicine of Columbus and Franklin County was one of the first in the state to respond to the OSMA's state-wide call for help.

"We, as physicians, can donate our own services, but we can't cover the costs of someone's hospitalization, medication, X-rays, lab fees, and so on," says Dr. Barnes. "Therefore it is important that other health care components become involved — hospitals, pharmacies, neighborhood health centers, government. . . ."

"Project Health Concern" was launched in Columbus last February, and since that time some 2,500 calls have come into the Academy's office. Nearly 500 of those callers were linked up to participating physicians, with another 300 referred back to their own physicians.

"Whenever possible, we urge

first in the state to get off the ground last February and, to date, nearly 2,000 patient referrals have been made to the 1,500 participating physicians. The program there is administered by the Academy of Medicine of Cleveland, which not only has received the cooperation of its physician members, but also of a number of area hospitals, specialty groups and community support groups. Funding for the project has been donated by contributors as diverse as the Gannett Foundation, SOHIO, and UAW Local 420.

In Toledo, where glass companies and auto parts suppliers — both heavily dependent on auto sales to stay in business — are major employers, "Academy Med-Assist" was set up last March to ease the loads in hospital emergency rooms where patients were seeking help as a last resort.

"As the auto industry has continued

"What we've found is that often people are too reluctant to discuss finances with their doctors."

patients to continue seeing their own physicians," says Ann Clinger, associate executive director of the Academy. "But what we've found from this project is that often people are too reluctant to discuss finances with their doctors. They're too proud to admit they're having problems or to ask for help. So they just don't go."

Therefore, the Academy acts as a kind of liaison between the patient and the doctor and makes the necessary arrangements for care; in Columbus, patients pay according to a schedule based on need and income.

"We've dealt with cases where pregnant women had waited until their seventh and eighth month to see a doctor," Clinger says. "We had one case where a woman was taking her sister's medication because she ran out of her own and she couldn't afford to see her doctor. . . . People (without jobs) are terrified to use the emergency room."

Perhaps the problems have been most acute in the north and northeastern parts of the state, in cities like Cleveland, Akron, Youngstown, and Toledo where unemployment rates have been among the highest in the country.

Cleveland's "Project 83" was the

to decline over the past three or four years, laid-off workers were letting their health problems go to the point where they were becoming emergencies," says Gerald Marsa, MD, who is heading up "Academy Med-Assist" for the Academy of Medicine of Toledo and Lucas County. "Our project was established to let them know they could continue to get routine health care without waiting for a problem to become an emergency," Dr. Marsa says.

To date, over 250 patient-families have enrolled in the program and some 500 physicians are participating.

The unemployment rate stood at 14.9% — the second highest in the state — when the Mahoning County Medical Society opened its planning and referral service for the recently unemployed in the Youngstown area. "These are people who have skills and capabilities that eventually will put them back into the workforce," says Robert Blake, executive director of the society. "But in the meantime, they are unemployed, their compensation has run out, and they are not eligible for any welfare programs."

Blake says Youngstown physicians in the program are displaying special signs in their offices, urging their

patients to discuss their financial problems with them. Doctors are adjusting fees on an individualized basis, with some reducing their charges, others deferring them, and still others charging nothing at all.

In Akron, where "Project Summit" got off the ground October 1, a sliding fee scale is used, ranging from zero cost to full payment. Patients calling "INFO LINE," a United Way-sponsored referral service, are first given the name of a primary care physician who acts as a "gatekeeper" before referring them on to a specialist in the program, if necessary.

And in Dayton, where "Project-MEND" (Medical Effort for the Needy of Dayton) was launched in April by the Montgomery County Medical Society and its Auxiliary, non-emergency medical care for the area's unemployed is absolutely free. There, Auxiliary volunteers act as a referral service, screening callers for eligibility and directing them to the 329 participating physicians. As of late summer, over 1,000 calls had been received and 370 patients had been referred.

Perhaps the most atypical program in the state is taking place in Massillon and its surrounding townships in Western Stark County. The unemployment rate in that community of former Republic Steel Corporation workers had peaked at nearly 17% when the Stark County Medical Society began discussing the possibility of organizing health care programs for the unemployed there. When it could not, society president, John Carpathios, MD, approached the Massillon Community Hospital with the project and found that nearly 100% of the physicians there were willing to participate. Over 300 appointments have been scheduled through the "MCH Medi-Share" project. The program is being monitored from month to month Dr. Carpathios says, but will be continued as long as there is a need or until an alternative program is implemented at the governmental level (See "Health Care Bills Pending").

Many communities, including Massillon, have seen substantial declines in the unemployment rate since their programs began, and subsequently in the calls they are receiving. There was a slight increase in that rate, however, by August, and with economic indicators predicting unemployment will continue to be a

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"I don't think there's a question of should we continue it. The question is how can we continue to best serve the needs of those needing this kind of service."

Health care bills still pending

Since the first of this year, a number of bills have been introduced both in the U.S. Congress and the Ohio Legislature concerning health care for the unemployed. The establishment of a government program to provide health care insurance and/or benefits for the recently unemployed appears to be of primary interest to representatives at both levels of government. Such legislation could supplement those health care programs already undertaken by the local county medical societies. As of press time, all bills still were pending.

At the state level, the most current of these bills is H.B. 215, which passed the Ohio House June 14 and currently is in the Elections and Financial Institutions Committee of

the Ohio Senate. That bill would require certain employer-sponsored group health insurance policies and self-insurance plans to continue covering terminated employees for six months at the group rates.

The bill also would authorize several classes of health care insurance (or other plans) to form an association to sell group health coverage to unemployed persons. Therefore, the newly terminated employee could opt to continue his or her employer's group coverage or could instead select an association policy. Upon expiration of the employer-sponsored group policy, the employee could purchase coverage under an available association group policy.

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Health care bills still pending

continued

H.B. 345, introduced April 27, takes a different approach. It directs the state's superintendent of insurance to prescribe, administer and regulate a basic health insurance benefit plan for recipients of unemployment compensation and their spouses and dependent children.

The bill also would create an insurance advisory committee to establish a competitive bidding process for the selection of one or more insurers to provide insurance under an Ohio Unemployed Health Insurance Plan. The committee would consist of the governor, the superintendent of insurance, the administrator of the Bureau of Employment Services and representatives of both parties from both the House and the Senate.

Because the implementation of either program would require substantial state resources, action is not expected until after the November 8 election when State Issues 2 and 3 will be decided. State representatives both in the house and senate also are awaiting the outcome

of numerous bills introduced by Congress, some of which would provide matching funds for state-sponsored or administered programs.

On the federal level, ten bills have been introduced by members of both parties from around the country, including five in the House and five in the Senate. These bills offer a variety of mechanisms through which health care insurance and/or benefits could be made available to the recently unemployed and their families.

Among the most popular is S. 951, introduced by Senator Dole (R-KS). This bill would amend Title XX of the Social Security Act, providing matching federal funds for state-administered programs. Participating states would be allowed to charge a weekly premium of up to 8% of a person's weekly unemployment compensation as a cost-sharing measure. The programs would be handled by those state agencies already administering the Medicaid program.

Other bills have been sponsored

by Senators Riegle, Specter, Kennedy and Quayle, along with Representatives Waxman, McDade, Walgren and Rostenkowski. Again, the financing of the programs seems to be the key issue, particularly as President Reagan has said he will veto any health insurance for the unemployed bill that is not self-financing. — *Susan Porter*

Pressure

continued

long-range problem in this state, many of these programs, initiated as temporary measures, may end up lasting longer than previously expected.

"I don't think there's a question of *should* we continue it, Clinger says of the Columbus program. "The question is *how* can we continue to best serve the needs of those needing this kind of service."

In Medina, where "Project 83" was initiated last March by the Medina County Medical Society, the program was scheduled for evaluation in October. Executive Secretary John E. Gerding said just prior to that evaluation, "The program is being used and has been successful. We are hoping it will be continued. Even in good times, there will always be people with this kind of need — people who don't qualify for Medicaid because they have some resources, but their current cash position makes it difficult for them to afford health care."

The recent recession has brought the issue of medical care for the unemployed to the forefront; however, it is by no means a new problem. Rather, health care for the needy — no matter what the circumstances — is as old as the medical profession, itself, and most doctors have always been willing to do their share.

As one Columbus physician stated recently, "I simply cannot imagine any physician turning away a patient who asks for help and explains that he or she is unable to pay for the service . . . I certainly intend to take care of those patients who supported me when they were able to do so." **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

THE OHIO PAIN AND STRESS TREATMENT CENTER

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After several years of double-digit unemployment levels, the realization that this might not be a temporary condition resulted in a general state of shock, disbelief and despondency.

UNEMPLOYMENT AND THE SUICIDE RATE

*By Robert G. Filby, MBA and
Geary M. Eicher, Jr., MD*

ABSTRACT: This article focuses on the correlation between the unemployment level and the suicide rate in Jefferson County, Ohio. The longitudinal study encompassed Coroner's Office statistics between January 1973 and June 1983. Although various linkages were explored between economic indicators and unemployment, the most positive correlation existed between the unemployment level and the frequency of suicides.

The intent of this article is to present the findings from a longitudinal study linking the unemployment level with the suicide rate in a small metropolitan area. Jefferson County, Ohio, was chosen as a typical industrial community of just under 100,000 in population which has been hard-hit with sustained high unemployment, the steel industry slow-down, and a declining and aging population.

Researchers have studied patterns of unemployment and have shown that as unemployment increases, the state of health of the nation-at-large

declines. Circumstantial evidence of this phenomenon is becoming more impressive and the link between unemployment, particularly sustained high unemployment, and ill-health is becoming a more recognized factor.

Without question, the foremost researcher in the area of unemployment and health is Johns Hopkins University Professor M. Harvey Brenner. Dr. Brenner has been studying this topic for over twenty years and his research has suggested that for each one million unemployed people in a society over a five year period, there would be 50,000 more deaths from general illnesses; 157,000 more deaths from heart disease; and 63,900 more admissions to psychiatric hospitals.¹

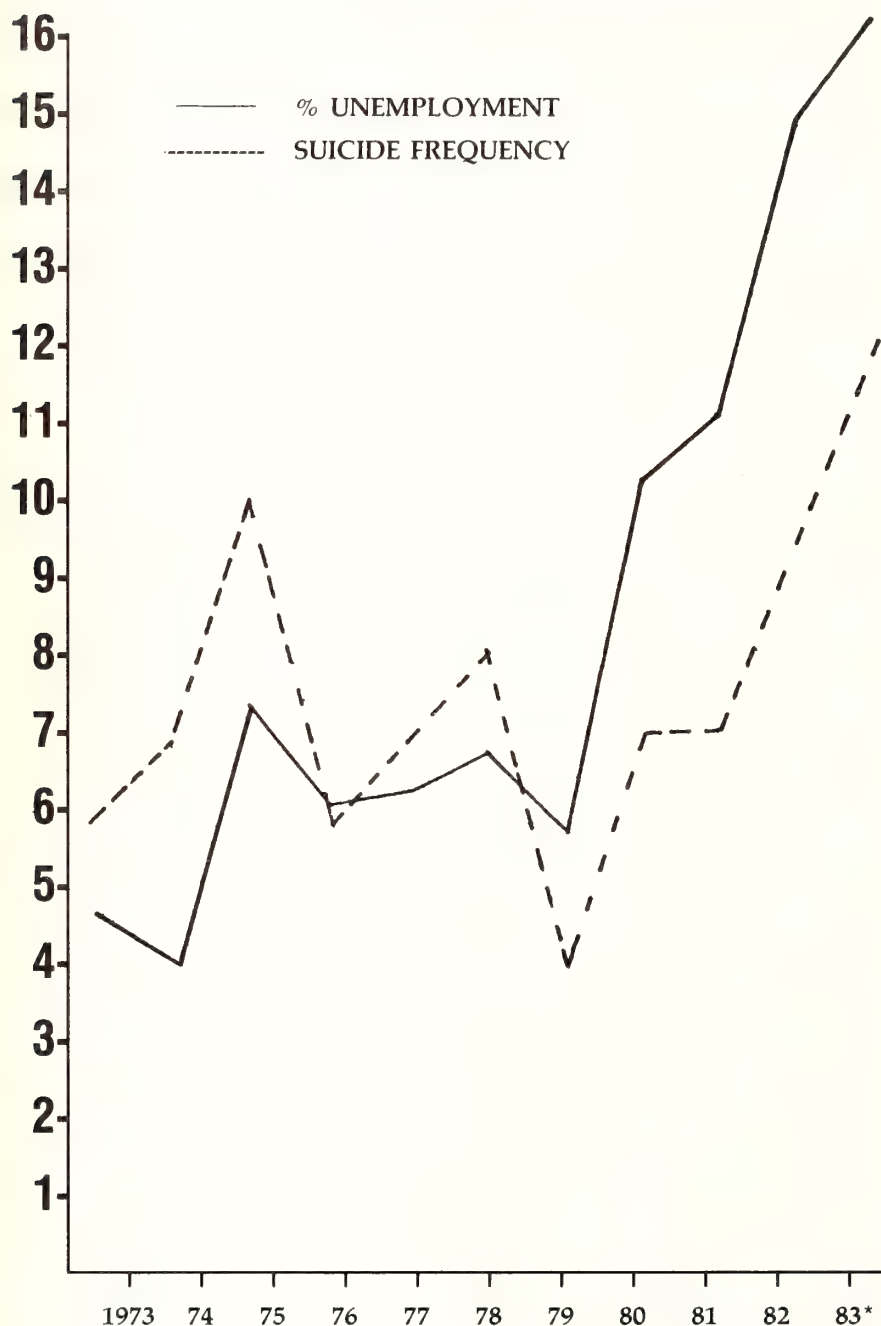
In the Ohio State Medical Journal of October 1978, Drs. Ackerman and Vaeth presented a review of the literature and discussed research methodology regarding the relationship between unemployment and health.² The focal point of this presentation is the positive correlation between unemployment levels and the frequency of suicides during the study period (see illustration 1).

While suicide is the tenth leading cause of death in the United States, it was recently ranked as the eighth leading cause of death in the State of Ohio.³ In the Jefferson County study, 60% of the suicides were by firearms, 24% by asphyxiation (carbon monoxide/hanging), 14% by drug overdose, and one case was categorized as "other" which will be discussed later. On a national level, only the rate of suicide by firearms has risen, while all other methods remained the same.⁴

The group most prone to suicide in the research study was the 20-29 age bracket (see illustration 2). Over 30% of the suicides during the study period were persons in this group. A substantial percentage of the successful suicide attempts were males, who took their lives by a 4:1 margin over the females. The males also took a more violent and direct route to self-destruction, such as placing a shotgun in the mouth. It is further noted that only one of the female suicide victims chose a method which would disfigure the face.

Statistics on suicide may be

ILLUSTRATION 1
UNEMPLOYMENT AND SUICIDE CORRELATION



*JANUARY-JUNE 1983

SOURCE: UNEMPLOYMENT DATA — OHIO BUREAU OF EMPLOYMENT SERVICES
SUICIDE DATA — JEFFERSON COUNTY CORONER'S OFFICE

generally unreliable and understated. To certify that death was the result of a suicidal act, it is incumbent upon the physician to determine with reasonable medical certainty that the act was intentional, self-inflicted, and meant to result in death. The physician must constantly be alert that every case resembling suicide may not actually be a suicide. A prime example of this, was the "death-by-hanging" of a 32-year-old married male employed as a coal company supervisor. Careful evaluation of the death scene, in-depth analysis of the circumstances, and a complete autopsy verified the cause of death as "autoerotic asphyxia." This death was then properly classified as an accidental death, rather than a suicide.⁵

Suicide notes were found in about 25% of the Jefferson County cases, which mirrors national statistics. It must be proven that the note is in the decedent's handwriting, and was written in the same general time reference as the act itself. It is a well established fact that families often hide a suicide note, frequently alter the death scene, and deliberately withhold or falsify information to conceal a suicide.

The word "suicide" in our society has had a bad connotation, and many are ashamed of suicides within their families. Most are concerned that "suicide" on the death certificate may invalidate the decedent's life insurance.

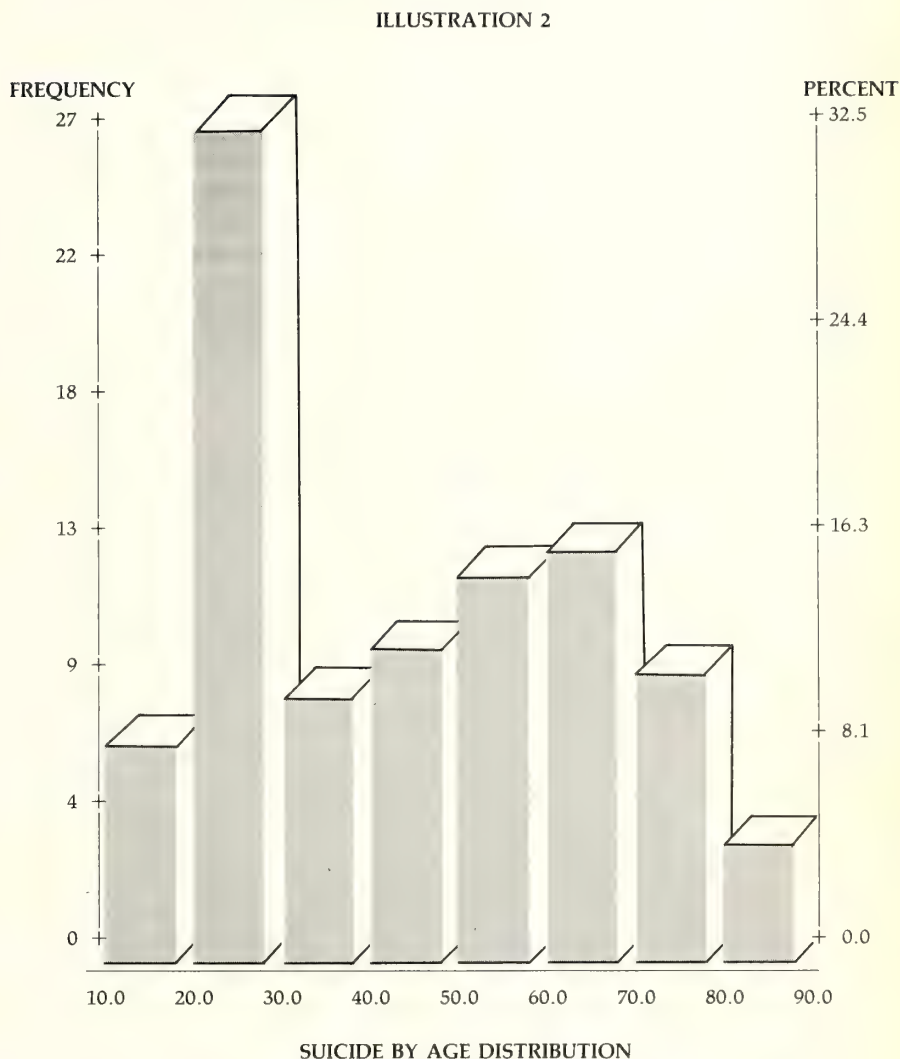
Although admittedly from a small metropolitan area, the case-mix in Jefferson County has been astonishingly similar to that seen in larger metropolitan centers. Some of the cases have been rather bizarre, as exemplified by the 62-year-old man whose labor union was on strike in a bitter cold December. A few days before Christmas, having decided to commit suicide, he went to his game room and removed the cover from the floor drain. He then laid down on the tile floor with his neck over the opening, and placed a circular saw to his neck and squeezed the trigger —

virtually decapitating himself.

For years, Jefferson County had enjoyed a healthy economic environment with practically unlimited job opportunities in the steel and coal industries. After several years of double-digit unemployment levels, the realization that this might not be a temporary condition resulted in a general state of shock, disbelief, and despondency. A large segment of the local work force realized that their job skills were no longer needed, and that their joblessness was a reality. As a result, many workers have taken early retirement with reduced pensions. Some of the young, who always believed that employment opportunities would be assured, have been unable to find jobs, thereby reinforcing this reality.

There has been a growing attitude of helplessness and hopelessness. Many have been unable to keep their health insurance active.

There has been a growing attitude of helplessness and hopelessness. Many have been unable to keep their health insurance active. There are frequent instances where the unemployed male finds himself supported by his spouse who has been able to gain employment. Some of the suicides — on the surface — have appeared to be the result of deteriorated marital relationships, but upon closer examination, unemployment and consequent financial and emotional torments have been found to be the nidus upon which the marital difficulties originally developed.



SOURCE: JEFFERSON COUNTY CORONER'S OFFICE

Everyone who experiences joblessness does not react in the same manner. There is evidence, however, that losing one's job can increase health risks, exacerbate chronic and latent disorders, alter usual patterns of health-seeking behavior, and exact numerous other social and intrapersonal costs.⁶

One emergency department physician theorized that the greater the number of dependents the unemployed person is responsible for, the greater the suicide potential. He further indicated that adolescent

suicides seemed to be related to stress factors with peer pressures, school, and interpersonal relationships.⁷ Other research has yielded findings of a relationship between adolescent suicide and a family background of marital instability, economic stress, disruption of residence, and long and bitter parent-child conflict.⁸

In summary, the Jefferson County study reflected a direct correlation between the level of unemployment and the number of suicides that occurred in any given year during the

continued on page 848

JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

Unique, once-daily formulation providing comprehensive cardiovascular protection

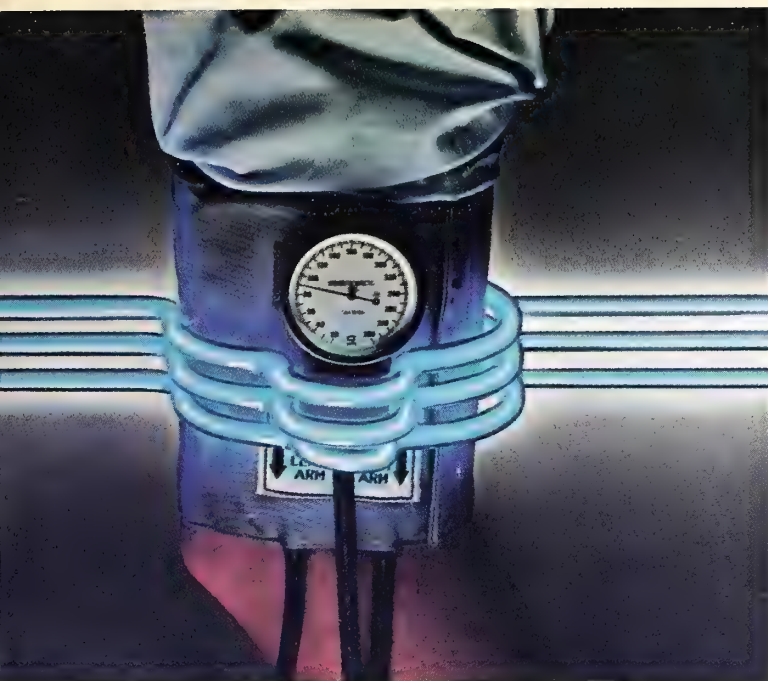
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL—with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

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THE
ONE
TO COUNT ON

Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg



120 mg



160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

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INDERAL[®] LA

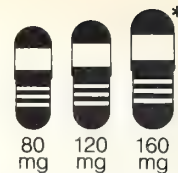
(PROPRANOLOL HCl) LONG ACTING CAPSULES

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**The one to count on
for HYPERTENSION, ANGINA
and prevention of MIGRAINE.**

ONCE-DAILY

INDERAL[®] LA
(PROPRANOLOL HCl) LONG ACTING
CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR)
INDERAL[®] LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antianginal effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE.** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension, paresthesia of hands, thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.
PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of Inderal LA capsules is a registered trademark of Ayerst Laboratories.

8588/883

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The Physician and Ohio Law

MINOR'S STATUTE OF LIMITATIONS FAILS CONSTITUTIONAL CHALLENGE

By Brent Mulgrew

On August 24, 1983, the Supreme Court of Ohio, by a vote of 6-1, set aside the statute of limitations for minors in effect since the enactment of Amended Substitute House Bill 682 in 1975. The decision in *Schwan v Riverside Methodist Hospital* comes only two months after the imposition of the "Discovery Rule" on the statute of limitations by the Court in *Oliver v Kaiser Community Health Foundation* (See OSMJ Vol. 79, No. 8, August 1983, pp. 609-611).

In 1975, the General Assembly enacted R.C. 2305.11 (B) to reduce the risk of potential medical liability for a limitless period. The statute established an absolute limit of four years after the act or omission constituting the alleged malpractice occurred. This provision gave physicians and their insurance companies a defense to claims based on acts or omissions occurring more than four years earlier.

Section 2305.11 (B) provides:

"In no event shall any medical claim against a physician, podiatrist, or a hospital or a dental claim against a dentist be brought more than four years after the act or omission constituting the alleged malpractice occurred. The limitations in this section for filing such a malpractice action against a physician, podiatrist, hospital, or dentist apply to all persons regardless of legal disability and notwithstanding section 2305.16 of the Revised Code, provided that a minor who has not attained his tenth birthday shall have until his fourteenth birthday in which to file

an action for malpractice against a physician or hospital."

This section, in effect, eliminated the "legal disability of minority" after age 10 and required a minor of 10 years of age or older to file a medical malpractice action within the time limits set forth in R.C. 2305.11 (A) and (B). After the recent decision in *Oliver*, an individual has one year after the patient discovers or with reasonable care and diligence should have discovered the results of the alleged malpractice. If the plain words of 2305.11 (B) O.R.C. have any meaning left, there continues to be a four year absolute limit in which to bring a claim after the act or omission constituting the alleged malpractice occurred. However, the interpretations and decisions by the Court this term leave that conclusion open to question.

In *Schwan*, the Court stated that the "classification created by R.C. 2305.11 (B) fails to rationally further the stated objective of Am. Sub. House Bill 682. This makes R.C. 2305.11 (B) constitutionally unacceptable with respect to medical malpractice litigants who are minors." The Court held that the section regarding minors creates a distinction "without reasonable grounds" between medical malpractice litigants who are younger than 10 years of age and those who are older than 10 but still minors. The Court argued that the only rational distinction for age would be "the age of majority."

The Court distinguished earlier cases of *Baird v Loeffler* (1982, 69 Ohio State 2nd 533) and *Meros v University*

Hospital (1982, 70 Ohio State 2nd. 143). The Court, in holding the statute violative of the constitutional right to equal protection, effectively eliminates the utilization of the statute of limitations as a defense in medical malpractice claims by minors.

Justice Clifford F. Brown, in his concurring opinion, argued that the statute was not only violative of the constitutional requirement for equal protection under the laws, but also that it violated the due process provisions of the Ohio constitution.

The trial court originally granted a summary judgment for the hospital because the patient was 14 at the time of the treatment and did not file his complaint of malpractice against the hospital within the one year time limit required by 2305.11 (B). The decision was reversed by the Court of Appeals for Franklin County which found the law unconstitutional. The Supreme Court affirmed the Court of Appeals decision. This means that minors will have until they are 18 plus one year to file a medical claim.

The statute of limitations must be considered with the newly applied "Discovery Rule." This means that even if the claim is filed after the one year statute of limitations has run, the defense will have to go to trial to show that the plaintiff, under the exercise of reasonable care and diligence, should have discovered the results of the alleged malpractice within the one year statute of limitations. Many more malpractice cases will go to trial because the defense will not be able to get

continued on page 845

*I can do things that I
couldn't do for 3 yrs. including
joining the human race again."*



*Quotes from an unsolicited
letter received by Pfizer from an
angina patient. While this patient's experience
is representative of many
unsolicited comments received,
not all patients will respond to
Procordia, nor will they all
respond to the same degree.*

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*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

*Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA[®]
(NIFEDIPINE) Capsules 10 mg

Please see PROCARDIA brief summary on adjoining page.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: 1. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

2. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: **General:** **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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LABORATORIES DIVISION
PFIZER INC.

The Physician and Ohio Law

continued

summary judgments.

The Ohio State Medical Association filed an amicus curiae brief, urging reversal of the Court of Appeals decision. Our arguments were not persuasive to the Court.

Supreme Court Abolishes Absolute Immunity For Independent Physicians Workers' Compensation Claimants

The OSMA also filed an amicus curiae brief in a case decided September 7, 1983 by the Supreme Court of Ohio concerning physician immunity for providing medical reports and testimony for the Workers' Compensation system. The original action was filed in the Court of Common Pleas of Lucas County by 14 Workers' Compensation claimants against the Industrial Commission of Ohio and William J. McCloud, MD. The complaint alleged that Dr. McCloud had examined 12 of the individuals and that his examinations were inadequate and incomplete and that the reports of these examinations contained intentional misrepresentations resulting in a denial or reduction in their Workers' Compensation benefits. That action sought a judgment against Dr. McCloud for compensatory and punitive damages.

At the trial level, Dr. McCloud received a summary judgment in his favor, on the basis that the function being performed in examining the claimants and filing material reports was that of a witness furnishing testimony in an adjudicatory proceeding which entitled him to absolute immunity. The Court of Appeals reversed part of the decision, stating that "a doctor who has undertaken a duty to examine an individual for the purpose of reporting

continued on next page

The Physician and Ohio Law

continued

the medical condition of that individual to an adjudicatory body is liable for any damages resulting from said doctor's failure to conduct a medically adequate examination, notwithstanding the report thereon is privileged under the doctrine of witness immunity."

In its amicus brief, the Ohio State Medical Association argued that the Lucas County Court of Appeals decision, if permitted to stand, would subvert the public policy reasons for the absolute immunity doctrine. "Under the court's decision, if a complainant is displeased with the award of the Industrial Commission's decision, he can file a suit against the examining physician, claiming the inadequate examination and thereby indirectly attack the report of the physician, which is supposed to be privileged. This would have just the

type of chilling effect on the uninhibited and independent administration of justice which the doctrine of absolute immunity is intended to prevent.

The OSMA argued that Dr. McCloud's examination of claimants was as much a part of the Ohio Industrial Commission proceedings as was his report. Both were made at the request of the Commission, and the reports could not have been made without the examinations. The OSMA believes Dr. McCloud's examinations for the purpose of making a report are no more severable than a judge's opinion in his inquiry into the law and facts or a jury's verdict and its attentiveness and presence during the trial. If absolute immunity is to have any beneficial effect in cases such as this one, it must apply to both the examination and the report.

Otherwise, a person dissatisfied with a physician's report can always bring a lawsuit alleging inadequacies in the examination.

Justice J.P. Celebrezze, writing for the majority, rejected the OSMA argument and concluded that Dr. McCloud's function of conducting out-of-court physical examinations of claimants was not "intimately associated" with the quasi-judicial phase of the procedures for application of benefits. Therefore, the reasons for extending absolute immunity are absent. Justice Celebrezze stated, "We must stress that Dr. McCloud's potential liability here is not predicated on his furnishing testimony at an adjudicatory proceeding or his submission of a medical report, but rather on the manner in which he conducted his

continued on page 861

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Lease from 6 to 48 months.



Continuing Education Programs

December

ONE DAY SEMINAR ON ONCOLOGY: December 8; Netherland Plaza Hotel, Cincinnati; sponsor: American Cancer Society; co-sponsor: University of Cincinnati College of Medicine, Department of Ob/Gyn; 6 credit hours; fee: \$100, \$50 for residents and other health professionals; contact: Susan F. Green, University of Cincinnati College of Medicine, Room 4509, M.L. 526, Cincinnati 45267, phone: 513/872-5441.

January

URO-RADIO-PATHOLOGY SEMINAR: January 12-14; Westin Hotel, Cincinnati; sponsor: University of Cincinnati Medical Center, Division of Urology; 19 credit hours; fee: \$200; contact: Division of Urology, M.L. 589, University of Cincinnati Medical Center, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4383.

MULTI-SPECIALTY SYMPOSIUM IN CURRENT LASER CONCEPTS: January 14-21; Ocho Rios, Jamaica; sponsor: University of Cincinnati Medical Center; 30 credit hours; contact: Robbie Cornelison, Program Coordinator, Dept. of Otolaryngology and Maxillofacial Surgery, University of Cincinnati Medical Center, Mail Location #528, Cincinnati 45267, phone: 513/872-4155.

Candidates for nutritional therapy...

25,500,000 geriatric patients.

The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.*



Berocca Plus. A balanced formula for prophylactic or therapeutic nutritional supplementation. Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

...candidates for

Rx ONLY **Berocca[®]
Plus** TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

*Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME: Philadelphia, Lea & Febiger, 1980, p. 781.

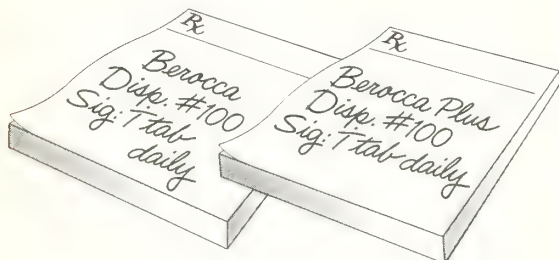
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Rx ONLY Berocca® Plus TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

also available as Rx ONLY Berocca® TABLETS



Before prescribing, please consult complete product information, a summary of which follows:

Each Berocca® tablet contains: 500 mg vitamin C (ascorbic acid), 15 mg vitamin B₁ (as thiamine mononitrate), 15 mg vitamin B₂ (riboflavin), 100 mg niacin (as niacinamide), 4 mg vitamin B₆ (as pyridoxine HCl), 18 mg pantothenic acid (as calcium d-pantothenate), 0.5 mg folic acid, 5 mcg vitamin B₁₂ (cyanocobalamin).

Each Berocca® Plus tablet contains: 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as dl-alpha-tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B₁ (as thiamine mononitrate), 20 mg vitamin B₂ (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B₆ (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B₁₂ (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

INDICATIONS: Berocca—Supportive nutritional supplementation in which water-soluble vitamins are required prophylactically or therapeutically, including conditions causing depletion, or reduced absorption or bioavailability of water-soluble vitamins, conditions resulting in increased needs for water-soluble vitamins. Berocca Plus—Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: General: Certain conditions may require additional nutritional supplementation. During pregnancy, vitamin D and calcium supplementation may be required with Berocca Plus or supplementation with fat-soluble vitamins and minerals may be required with Berocca. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease efficacy of levodopa in treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca and Berocca Plus. Allergic and idiosyncratic reactions are possible at lower levels. Iron, even at recommended levels, has been associated with GI intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Available on prescription only. (Berocca Plus is not recommended for children.)

HOW SUPPLIED: Berocca—Light green, capsule-shaped tablets—bottles of 100 and 500. Berocca Plus—Golden yellow, capsule-shaped tablets—bottles of 100.



ROCHE LABORATORIES
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Nutley, New Jersey 07110

Unemployment and Suicide

continued

longitudinal investigation. As the level of unemployment increased, so did the number of suicides. At the same time, the average age of the suicide victims declined as the frequency increased.

OSMA

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8. Tishler, Carl L: "Adolescent Suicide: Prevention, Practice, and Treatment." *Ross Timesaver* Vol 23 No 6 Nov-Dec 1981.

Robert G. Filby, MBA, Steubenville, is Senior Vice President, Professional Services, St. John Medical Center. Geary M. Eicher, Jr., M.D. is Coroner for Jefferson County.

Get-sober-quick products slow to win FDA approval

Bad news for Ohioans who were hoping for fast relief from the new drunken driving law. It will be a while before those new get-sober-quick products hit the market. The Food and Drug Administration (FDA) has taken action to prevent the sale of products which claim to prevent or lessen the effects of inebriation by classifying the products as new drugs. As a result, the products cannot be sold unless studies are submitted to prove safety and effectiveness. Thus far, the FDA has received no such evidence.

INTRODUCING
THE

ONE

TO COUNT ON

NEW

ONCE-DAILY

INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



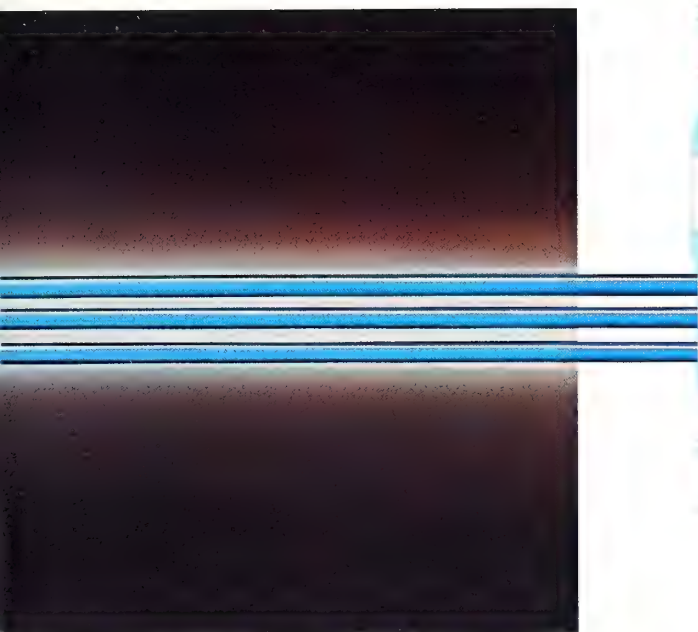
THE ONE
TO COUNT ON
FOR THE EXPERIENCE
OF INDERAL—

**A unique controlled-release
formulation offers effective
24-hour beta blockade**

Regardless of pH or contents in the GI tract, INDERAL is diffused from small spheroids at a controlled and predictable rate.

**Providing clinical results
equivalent to tablets**

In controlled clinical studies, a single daily dose of INDERAL LA provided the same therapeutic response as equivalent doses of conventional INDERAL tablets. While there is little correlation between plasma levels and clinical effect in hypertension and angina, blood levels achieved with INDERAL LA are usually lower than those achieved with an equivalent mg dosage of conventional INDERAL due to differences in hepatic metabolism.



THE
ONE
TO COUNT ON

WITH ONCE-DAILY DOSAGE

In hypertension, angina,
and migraine

Smooth 24-hour control

Unsurpassed simplicity
and convenience

Single daily dosage for
enhanced patient compliance

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



80 mg



120 mg

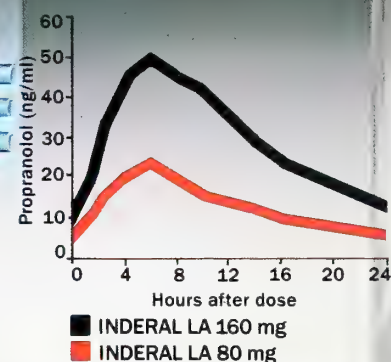


160 mg

The appearance of INDERAL LA capsules is a trademark of
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NEW
ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
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MEAN PLASMA LEVELS
ATTAINED WITH INDERAL LA
OVER 24 HOURS



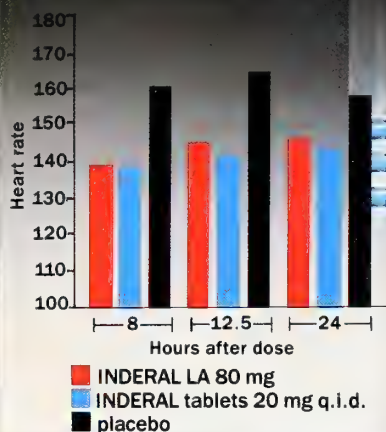
**THE ONE
TO COUNT ON
FOR SMOOTH
PLASMA LEVELS—**

Sustained plasma levels

In pharmacokinetic studies, blood levels with once-daily INDERAL LA were found to be adequate to maintain sustained clinical effect throughout 24 hours. The unique controlled-release formulation of INDERAL LA minimizes differences between peak and trough plasma concentrations.

THE ONE TO COUNT ON

EFFECT ON POST-EXERCISE HEART RATE OVER 24 HOURS*



AND 24-HOUR BETA BLOCKADE

Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose—with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg



120 mg



160 mg

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*INDERAL LA vs. tablets: N.S. at all hours measured.

*INDERAL LA vs. placebo: $p < .05$ at all hours measured.

NEW
ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

**THE ONE
TO COUNT ON
FOR INITIAL
THERAPY IN HYPERTENSION**



Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

**Unsurpassed convenience
and simplicity**

Enhanced patient compliance



THE
ONE
TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

**Compatible with
other conventional antianginal
therapies**

**The experience and protection
of INDERAL**

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



80 mg

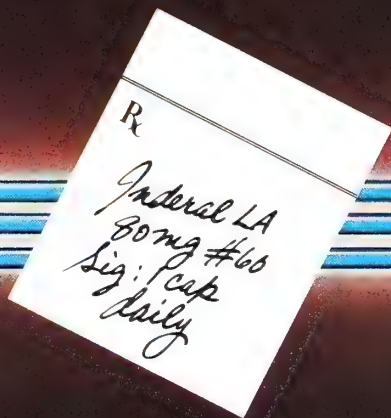


120 mg



160 mg

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THE
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TO COUNT ON

**THE ONE TO
COUNT ON FOR
THE EXPERIENCE
OF INDERAL
NOW WITH ONCE-
DAILY DOSAGE**

In hypertension, angina, and
migraine—start with 80 mg
once daily

Smooth 24-hour control

Unsurpassed simplicity and
convenience

Enhanced patient compliance

Three strengths for prescribing
convenience

For arrhythmias, use
conventional INDERAL® tablets

Ayerst®

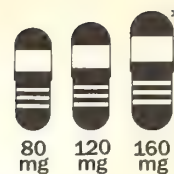
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Please see last page for Brief Summary of Prescribing Information.

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

ONCE-DAILY INDERAL[®] LA (PROPRANOLOL HCl)

LONG
ACTING
CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL[®] LA brand of propranolol hydrochloride

(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal LA is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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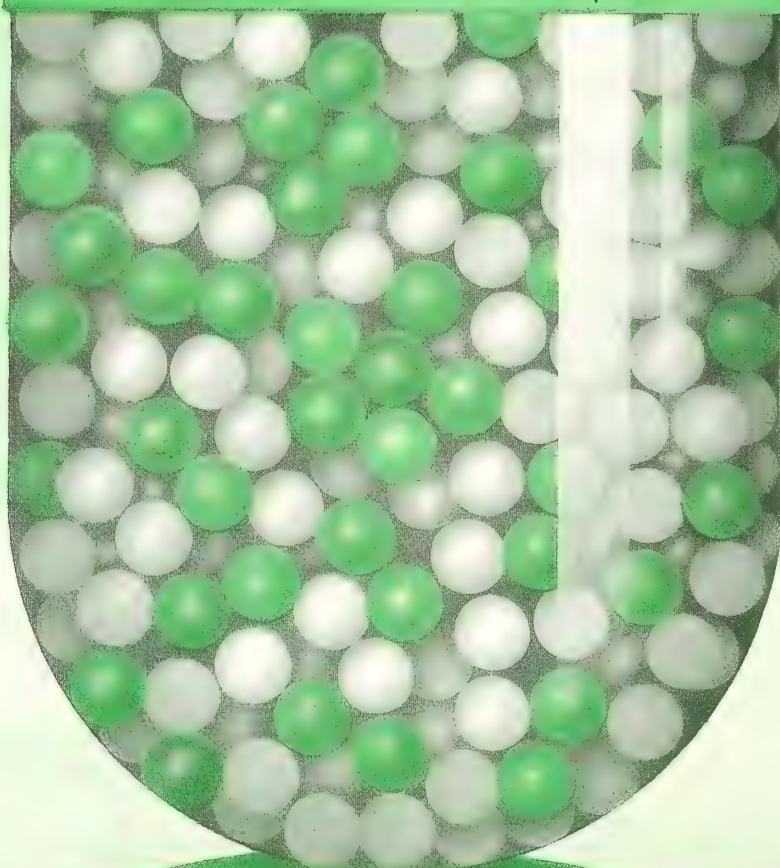
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DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.

INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage in pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated intestinal obstruction, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

Slight to moderate drowsiness occurs relatively infrequently with Chlorpheniramine Maleate. Other possible side effects common in antihistamines in general include perspiration, chills, dryness of mouth, nose and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteresis, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

DOSAGE AND ADMINISTRATION: Dosage should be individualized according to the needs and response of the patient. Adults: one capsule every 8 to 12 hours not to exceed 3 capsules daily. Not for use in children under 12 years of age.

OVERDOSAGE: Treatment of the signs and symptoms of overdosage is symptomatic and supportive. In the event of overdosage, emergency treatment should be started immediately.

Treatment: The patient should be induced to vomit, even if emesis has occurred spontaneously. Vomiting by the administration of ipecac syrup is a preferred method. However, vomiting should not be induced in patients with impaired consciousness. Stimulants (analeptic agents) should not be used. Vasopressors may be used to treat hypotension. Short-acting barbiturates, diazepam or paraldehyde may be administered to control seizures. Hyperpyrexia, especially in children, may require treatment with tepid water sponge baths or a hypothermic blanket. Apnea is treated with ventilatory support.

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earlier medical examinations of the appellees for the purpose of reporting their medical conditions to the Industrial Commission. Dr. McCloud's out-of-court physical examinations of appellees are investigative — medical fact-finding functions — not a quasi-judicial function . . . He is not a witness furnishing testimony at trial. . . ."

In a strong concurring opinion, Justice Clifford F. Brown wrote, "This decision is generated by a festering evil at the Industrial Commission, where a small minority of physicians, to whom the Commission refers claimants for examination and report, are willing to sell their expertise for a substantial price." He then attacked the briefs of amicus curiae that had argued that the absolute immunity rule for physicians engaged by the Commission was for the benefit of the people of Ohio, rather than for the benefit of witnesses.

Justice Brown retorted that "to instill fear of legal liability in physicians like Dr. McCloud, is an effective way to ensure they perform their functions with independence and honesty. The vast majority of physicians who perform honest, adequate and complete medical examinations of compensation claimants have nothing to fear from our decision today . . . While the physician is immune from liability for damages as a result of his submitting false or defamatory statements as to the medical condition of the individual examined, the physician may be held liable for damages on a theory akin to malpractice by virtue of his failure to conduct an adequate and complete examination."

Justice Sweeney, in his dissent, stated that the dichotomy created by the majority between the witness's out-of-court examinations and in-court testimony is "false insofar as it imputes a separate, independent legal existence to the necessary preliminary stages of an expert's participation in a case. To say that the function of conducting out-of-court physical examinations of claimants is not intimately associated with the quasi-judicial phase is to ignore the purpose

continued on page 871



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Obituaries



RAY W. BARRY, MD, Xenia; University of Cincinnati College of Medicine, 1941; age 73; died August 23, 1983; member OSMA and AMA.

CHARLES C. DEAMUDE, MD, Beverly; University of Louisville School of Medicine, Louisville, Kentucky, 1930; age 89; died August 5, 1983; member OSMA and AMA.

CHESTER W. DEWALT, MD, Columbiana; University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, 1920; age 87; died August 16, 1983; member OSMA and AMA.

RONALD W. FALLAT, MD, Cincinnati; St. Louis University School of Medicine, St. Louis, Missouri, 1965; age 44; died August 29, 1983; member OSMA and AMA.

THEODORE GUENTHER, MD, Cincinnati; University of Michigan Medical School, Ann Arbor, Michigan, 1940; age 68; died July 5, 1983; member OSMA and AMA.

BENJAMIN C. HOYER, MD, Cincinnati; University of Cincinnati College of Medicine, 1923; age 90; died July 5, 1983; member OSMA and AMA.

HUGH B. KELLY, MD, Cleveland; School of Physic Trinity College, University of Dublin, Ireland, 1944; age 62; died August 8, 1983; member OSMA.

FAY A. LeFEVRE, MD, Chagrin Falls; Case Western Reserve University School of Medicine, 1931; age 78; died August 30, 1983; member OSMA and AMA.

HARRY K. LYNNE, MD, Jefferson; University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, 1931; age 86; died August 11, 1983; member OSMA and AMA.

WILLIAM H. MILLER, MD, Columbus; Ohio State University College of Medicine, 1912; age 95; died August 18, 1983; member OSMA and AMA.

WALTER MUELLER, MD, Wappinger Falls, New York; Medizinische Fakultät der Universität, Wien, Austria, 1927; age 79; died June 13, 1983; member OSMA and AMA.

FRANK O'DEA, MD, Venice, Florida; Georgetown University School of Medicine, Washington, D.C., 1936; age 75; died July 4, 1983; member OSMA and AMA.

RAYMOND J. PY, MD, Amherst; University of Cincinnati College of Medicine, 1952; age 58; died August 4, 1983; member OSMA and AMA.

ALVIN H. ROEMER, MD, Indian Harbor, Florida; University of Cincinnati College of Medicine, 1938; age 70; died June 21, 1983; member OSMA and AMA.

THOMAS SHEHAN, MD, Scottsdale, Arizona; Ohio State University College of Medicine, 1933; age 78; died July 15, 1983; member OSMA and AMA.

MAX STRIKMAN, MD, Cincinnati; Eclectic Medical College, Cincinnati, 1928; age 80; died August 17, 1983; member OSMA and AMA.

WILLIAM TERWILLEGGER, MD, Scottsburg, Indiana; Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania, 1930; age 85; died August 15, 1983; member OSMA and AMA.

ELMER Z. TOMBOLY, MD, Brookville; Orvosi Fakultás Szeged University School of Medicine, Szeged, Hungary, 1940; age 69; died August 19, 1983; member OSMA and AMA.

CHARLES H. YORK, MD, Cleveland; Case Western Reserve University School of Medicine, 1925; age 85; died August 14, 1983; member OSMA and AMA.

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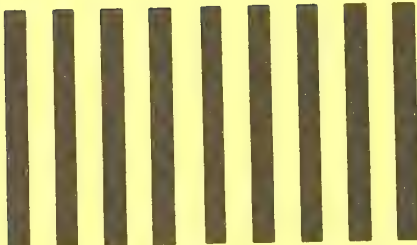
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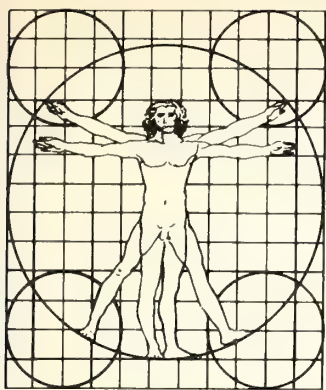
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CLINICAL & SCIENTIFIC

REPRODUCTIVE PERFORMANCE AMONG DES EXPOSED DAUGHTERS COMPARED WITH THAT OF THEIR MOTHERS

Thomas G. Kirkhope, M.D.

The reproductive histories of 54 women, exposed in utero to diethylstilbestrol (DES), were compared with those of their mothers. Another group of 51 daughters, whose mothers thought they had been exposed to DES during pregnancy, but in whom no evidence of this exposure could be found, also were compared. The DES-exposed daughters had a pregnancy failure rate of 58.3%, compared with their mothers' rate of 34.2%. The daughters in whom DES exposure could not be shown had a failure rate of 18.2% as compared with their mothers' rate of 42.0%. These data do not support the existence of a familial factor to explain the increased numbers of pregnancy losses in DES daughters.

Several recent articles have demonstrated an increased rate of pregnancy failure in DES-exposed daughters.¹⁻⁷ Rosenfeld,⁵ Pillsbury,⁷ and Kaufman, et al,⁸ have shown it to be related to hysterographic abnormalities, and Goldstein⁹ has indicated incompetent cervical os as a mechanism. The question has been raised^{8,10} as to whether a familial factor might be operative in these daughters. The mothers represent a population preselected because of an increased rate of pregnancy losses; therefore, an increased rate in the daughters might be expected.

The present study was undertaken to determine 1) what the experience of DES-exposed daughters in the Toledo area has been, and 2) whether the rate of pregnancy loss is related to a similar rate in their mothers, indicating a familial factor in the etiology.

From The Northwest Ohio Regional Perinatal Center at The Toledo Hospital.

Dr. Kirkhope, Toledo, Associate Maternal-Fetal Medicine Specialist, Northwest Ohio Regional Perinatal Center, and Vice Chairman, Department of Obstetrics-Gynecology, The Toledo Hospital; Assistant Clinical Professor, Department of Obstetrics-Gynecology, Medical College of Ohio.

This study was supported by a research grant from The Toledo Hospital. Reprint requests to Northwest Ohio Regional Perinatal Center at The Toledo Hospital, 2142 North Cove Blvd., Toledo, Ohio 43606 (Dr. Kirkhope).

Submitted May 11, 1982.

Materials and Methods

The sample consists of 158 young women from the Toledo area who are known or suspected to have been exposed to diethylstilbestrol in utero. Some were referred to the author by their private physicians because of this history. Others were self-referred in response to a local radio-TV-newspaper campaign aimed at locating these women and bringing them in for examination.

Found by the above methods were 158 young women who were scheduled for examination. In all patients, general medical and gynecologic histories were obtained, and pelvic and colposcopic examinations were performed. Two broad categories of patients were defined at the time of admission to the study as follows:

A. Forty-five patients could produce written, documented evidence through their mothers' prenatal records of having been exposed to DES. In these, not only the drug, but also the dose, stage of gestation and duration were known. In 37 of these (82.2%), definite, benign DES-related changes, as described by Sandburg,¹¹ Herbst,¹² and Stafl,¹³⁻¹⁵ were found in the vagina and cervix. In another 49 patients documented evidence was not available, but all demonstrated the same gross and/or colposcopic changes, thereby giving presumptive evidence of DES exposure. (One of these had already undergone abdominal hysterectomy and partial vaginectomy for clear-cell adenocarcinoma.) These 94 patients make up Group A.

B. In 64 patients, no documented evidence of DES exposure was obtainable, since their mothers' prenatal records had been lost or destroyed. The mothers themselves recalled using the drug with varying degrees of knowledge about the specifics of dose or duration. Some knew only that they had taken "some drug." Some of these women undoubtedly did receive the drug, but many probably did not. None of these daughters had objective findings, by gross or colposcopic examination, suggestive of DES effect. In 20 of them, however, there was some evidence consistent with exposure (usually colposcopic appearance of limited ectocervical adenosis). These were designated "equivocal findings" and included with the Group B patients.

Results

In the group of 94 women who satisfied the criteria of DES exposure by documented history and/or characteristic physical findings (Group A), there were 39 who were sexually active without contraception. The remaining either denied coitus or

TABLE 1.

Group A — Patients with documented histories and/or objective findings consistent with intrauterine DES exposure.

	Number	(Percent)
Number of patients	94	
Patients with:		
No coital exposure or regular contraceptive use	55	
Regular coitus without contraception	39	
Primary infertility	10	(25.6)
Women achieving pregnancy	29	(74.4)
Pregnancies	46	
Term births, live	22	(47.8)
Premature births	0	(0.0)
Spontaneous abortions	24	(52.2)
Elective abortions	0	(0.0)

were regular contraceptive users. The reproductive experiences of these 39 were as follows (see Table 1): Ten patients attempted to conceive for more than one year without success, for a primary infertility rate of 25.6%. The other 29 achieved a total of 46 pregnancies. Of these, 22 were delivered at term, and 24 aborted spontaneously, for a pregnancy failure rate of 52.2%. None of the patients in this group reported ectopic pregnancies, premature births or induced abortions.

Of the 64 patients with histories of DES exposure but no documented evidence (Group B), there were 24 sexually active without contraceptive use. Their reproductive histories were as follows (see Table 2): In these 24 patients there were three who complained of primary infertility, which was defined as regular coitus without contraception for a period of at least one year, for a primary infertility rate of 12.5%. The remaining 21 patients had a total of 41 pregnancies. Thirty-one of these resulted in full-term live infants. Two were electively aborted, and eight were aborted spontaneously. There were no premature deliveries or ectopic pregnancies. If only pregnancies not electively aborted are considered, there were eight spontaneous abortions in 39 pregnancies for a pregnancy failure rate of

TABLE 2.

Group B — Patients without documented history and with negative or equivocal findings.

	Number	(Percent)
Patients	64	
No coital exposure or regular contraceptive use	40	
Regular coitus without contraception	24	
Primary infertility	3	(12.5)
Women achieving pregnancy	21	(87.5)
Pregnancies	41	
Term births, live	31	(75.6)
Premature births	0	(0.0)
Spontaneous abortions	8	(20.5)*
Elective abortions	2	

*This percentage computed on a total of 39 nonelectively aborted pregnancies, since it cannot be known what the outcome of the electively aborted pregnancies might have been.

20.5%. If those with "equivocal" findings are excluded, there were 24 pregnancies not electively aborted, four of which aborted spontaneously for a pregnancy failure rate of 16.7%.

Reproductive histories were available in 105 of the mothers of these daughters. In the group of daughters with documented history and/or positive findings there were 54 whose mothers' obstetrical histories were available (see Table 3). These 54 mothers had had 158 pregnancies. Of these, 104 resulted in live term infants. There was one term stillbirth, three premature (less than 2,500 grams) infants, none of whom survived, and 50 spontaneous abortions, for a pregnancy failure rate of 34.2%. The pregnancy failure rate for the daughters in this group was 58.3%.

Among the mothers of daughters in whom DES exposure could not be demonstrated, there were 51 in whom the reproductive history was known. These 51 mothers had had 162 pregnancies. Of these, 90 resulted in live term infants. There was one term stillbirth. There were six premature infants, four of whom survived, and 65 spontaneous abortions. Pregnancy failure rate for this group, then, is 42.0%, as compared with 18.2% in their daughters (see Table 4).

TABLE 5.
Comparative results of studies of the reproductive histories of DES daughters.

	Herbst	Schmidt	Berger & Goldstein	Cousins	Toledo Hospital
Patients sexually active					
without contraception	131	106	69	—	39
Patients achieving pregnancy	89 (67.9)	75 (70.8)	46 (66.7)	29	29 (74.4)
Pregnancies achieved	149	129	80	43	46
Nonaborted, completed	116	93	62	27	46
Elective abortion	33	36	7	16	0
Term births, live	56 (48.3)	46 (49.5)	21 (33.9)	12 (44.4)	22 (47.8)
Stillbirths, term	1 (0.9)	4 (4.3)	0 (0.0)	0 (0.0)	0 (0.0)
Premature	30 (25.9)	12 (12.9)	8 (12.9)	8 (29.6)	0 (0.0)
Surviving	21	12	5	3	0
Not surviving	9	0	3	5	0
Spontaneous abortions					
(1st & 2nd trim.)	25 (21.6)	24 (25.8)	30 (48.4)	5 (18.5)	24 (52.2)
Ectopic pregnancies	4 (3.4)	7 (7.5)	3 (4.8)	2 (7.4)	0 (0.0)
Primary infertility	42 (32.1)	31 (29.2)	16 (23.2)	4	10 (25.6)

TABLE 3.
Group A — DES Exposure Confirmed

	Mothers		Daughters	
	#	%	#	%
Number of patients	54		54	
No coital exposure or regular contraceptive use	0		26	
Regular coitus without contraception	54		28	
Primary infertility	0		9 (32.1)	
Women achieving pregnancy	54		19 (67.9)	
Pregnancies	158		24	
Term births, live	104 (65.8)		10 (41.7)	
Stillbirths, term	1 (0.6)		0 (0.0)	
Premature births	3 (1.9)		0 (0.0)	
Spontaneous abortions	50 (31.6)		14 (58.3)	
Total pregnancy losses	54 (34.2)		14 (58.3)	

Discussion

Several authors now have confirmed an increased rate of pregnancy failure in DES daughters. The results of these studies are in agreement with our own findings as shown in Table 5. The multicenter study by Barnes, et al, also confirms these findings, but their results are not directly comparable since numbers of women were tabulated rather than numbers of pregnancies. Our own findings are also in agreement with others in showing an increased rate of primary infertility in DES-exposed daughters, although this was not found in the studies by Barnes or by Cousins, et al. It is not known why an increased number of premature deliveries was not found in our study, as seemed to be found in most other studies of this group of women.

As can be seen, the mothers of the women in both Groups A and B had poor reproductive histories. Both groups of mothers were given drugs in an attempt to support their pregnancies. Group A mothers received diethylstilbestrol, and Group B mothers may or may not have received this drug. The reproductive performance of Group B (DES-unexposed) daughters apparently is better than that of their mothers, and closely approximates that usually quoted for the general population. The performance of Group A daughters is significantly worse than that of their mothers, in whom the pregnancy failure rate already was high.

If a familial factor were operative, all daughters of these mothers would be expected to have a high rate of pregnancy loss. These data indicate, however, that the DES-exposed daughters have a higher reproductive failure rate than their mothers, while that of DES-unexposed daughters is lower — approaching the normal rate for the general population.^{16,17} The existence of a familial factor, therefore, is not supported.

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TABLE 4.
Group B — DES Exposure not confirmed

	Mothers		Daughters	
	#	%	#	%
Number of patients	51		51	
No coital exposure or regular contraceptive use	0		34	
Regular coitus without contraception	51		17	
Primary infertility	0		0 (0.0)	
Women achieving pregnancy	51		17	
Pregnancies	162		33	
Term births, live	91 (56.2)		27 (81.8)	
Stillbirths, term	1 (0.6)		0 (0.0)	
Premature births	6 (3.7)		0 (0.0)	
Spontaneous abortions	65 (40.1)		6 (18.2)	
Total pregnancy losses	68 (42.0)		6 (18.2)	

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The Physician and Ohio Law

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of referring a claimant to a specialist in the first place." He stated that the allegedly deficient examination standing alone caused no damages. "It was appellant's testimony before the Commission that provides the basis for the Commission's award, setting benefit levels at lower than those to which appellees believe themselves entitled. Thus, even if the dubious bifurcated-function theory advanced by the majority is adopted, the "damage remedy" created thereby is necessarily linked to the physician's testimony and not his examination."

This case is significant because the elimination of absolute immunity for preparation and examination in contemplation of quasi-judicial or judicial proceedings in Worker's Compensation claims cases creates a significant new potential liability for physicians. This office will continue to review the cases decided in this area.

On September 21, the attorney for Dr. McCloud filed a motion for rehearing in the Ohio Supreme Court. In his motion, he alleged that Justice Clifford F. Brown's remarks evidence "the absence of impartiality in resolving the issues."

State Medical Board Releases Opinion On "Immediate Supervision"

On September 9, 1983, the Ohio State Medical Board responded to a request from Blue Shield for an interpretation of Section 4731.35. (See Vol. 79, No. 9, September 1983 OSMJ, page 699). The Board issued the following response to the four questions delineated below:

I. What is the Board's definition of the word "immediate"?

The availability of the anesthesiologist within the operating suite or within a two (2) minute travel would, in our opinion, satisfy the requirement for the term "immediate" as used in Section 4731.35.

II. Who should be the "licensed physician" giving "direction?"

Our preference is for the nurse anesthetist to be supervised by an anesthesiologist licensed to practice medicine and surgery in the State of Ohio. If the hospital does not provide an anesthesiologist, the phrase "licensed physician" is satisfied by the presence of the licensed physician performing the particular procedure, i.e. the surgeon, who through sufficient training in the administration of anesthesia is able to meet minimum standards of patient care in accordance with Section 4731.22 (B) (6), O.R.C.

III. May the licensed physician supervise more than one nurse anesthetist simultaneously?

In our opinion, operating room design in modern hospitals and available technology will permit an anesthesiologist to supervise more than one nurse anesthetist at the same time and still be within the "immediate presence" for purposes of O.R.C. 4731.35. We do advise, however, that each medical staff in arriving at an appropriate ratio of supervision, consider its patient mix and available resources in arriving at a decision which will result in the delivery of quality medical care and anesthesia services, in accordance with minimal standards of care as required by the Medical Practice Act.

IV. May the nurse anesthetist bill the patient separately for services rendered?

O.R.C. 4731.35 specifically provides that any services rendered by a nurse anesthetist must be under the supervision of a licensed physician. Because of this requirement, it is apparent that a nurse anesthetist is not an independent medical practitioner and is not authorized to practice independently of a licensed physician. Therefore, since the nurse anesthetist cannot practice independently, it is our opinion that the nurse anesthetist cannot independently submit an invoice for services without reference to and the signature of the "licensed physician" who supervised the anesthetic procedure.

Lab Tests For Obstetrical Patients

In a related supervision issue, the State Medical Board released a position paper on whether certified nurse midwives are authorized to order laboratory tests for obstetrical patients. The Board, citing the case section (4731.33 O.R.C.) that requires the holder of a certificate of midwifery to practice under the direction and supervision of an MD or DO, concluded that "orders for laboratory tests for obstetrical patients should be signed by such (supervising) physician unless otherwise permitted or required by Ohio statutes. Further the interpretation of laboratory tests is solely the function of the physician. Interpretation of tests constitutes diagnosis, and is, therefore, the practice of medicine." **OSMA**

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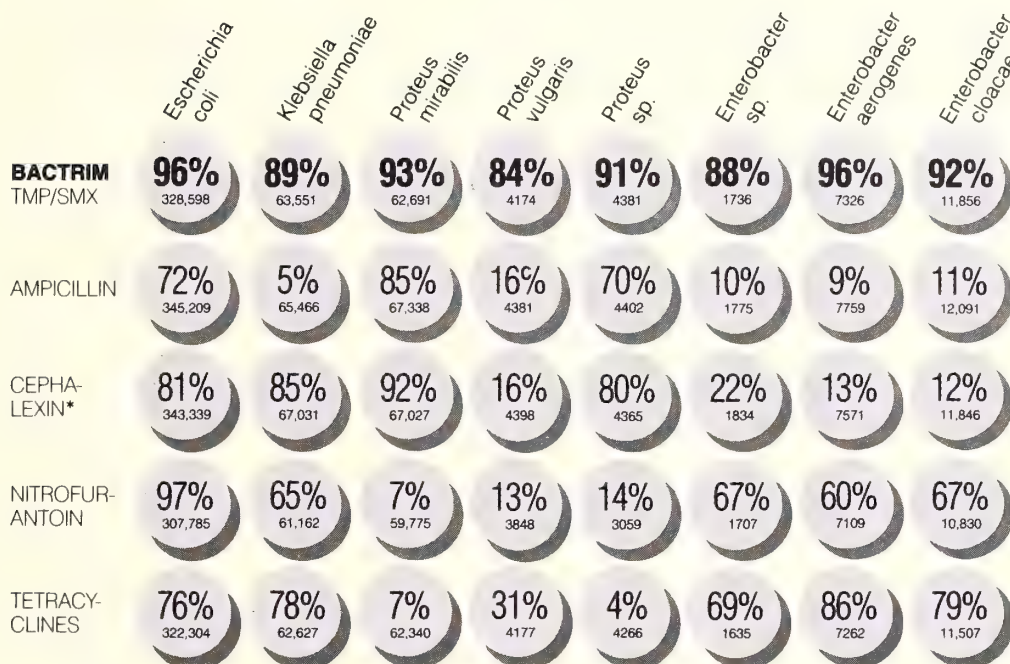
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Dosage: Not recommended for infants less than two months of age.

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S. Baird Pfahl, M.D.

PRESIDENTIAL PERSPECTIVES

Changing Patient Lifestyle It's Still Worth a Try!

By S. Baird Pfahl, MD

The words "cost effectiveness" mean different things to different people. To the physician, they may mean cutting the office overhead costs, group purchasing and expense sharing arrangements. To the insurance company, the words often indicate programs designed to lower or stabilize reimbursement to hospitals and physicians, e.g. pre-admission certification and participating agreements. To the hospital, cost

it, yet cigarette sales grow each year. Alcohol and other substance abuse continues to grow. Exercise is more popular, but still we see many patients whose major exertion each day is changing the TV channel (if they cannot afford a remote control).

I do not want to sound negative, but I have been involved in cost effectiveness since OSMA formed its committee in 1976, and we in medicine have not found the answer

We are stymied, however, by our inability to control a large aspect of medical costs — unhealthy lifestyles on the part of our patients.

containment can mean controlling group purchasing, cutting utility costs, management streamlining and fewer employees. To the patient, however, these words seldom mean very much.

Physicians have responded well to the challenge of costs but we can only cut our overhead so much — we still need lights, heat, phone, etc. We are stymied, however, by our inability to control a large aspect of medical costs — unhealthy lifestyles on the part of our patients. Many physicians have given up smoking and advise against

to influencing our patients' lifestyles to a significant degree. We must, however, continue to use our personal and organizational persuasions to help our patients. Our efforts in ordering tests, prescribing and patient care settings will all help keep costs down, but for us the "bottom line" is still quality medical care. By helping our patients improve their lifestyles, we can meet our goals and those of society — PLEASE KEEP TRYING . . . WE CAN SUCCEED. OSMA

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From the Editor's Desk

COST EFFECTIVENESS

Is time running out in the battle to cut health care costs?

Now what? You've done everything you can think of to cut your costs. You've cut and skimmed and saved every way you know how. You've met with business, you've made voluntary efforts, you've cooperated as much as possible with a government that keeps pulling the purse strings tighter and tighter. But as health care continues to consume larger portions of the gross national product, everyone — including your patients — seem to be clamoring for more and better ways to beat the high costs of getting (and staying) well.

Is there anything left for you to do — any other way to sanely cut costs without sacrificing the kind of quality medicine America has come to expect? Or is socialized medicine looming like a vulture on the horizon, hovering over a carcass that's already been picked pretty clean?

This issue of the *Journal* takes a closer look at cost effectiveness and the battle that's being waged on the health-care front. However, it's a subject that's become so complex in recent years it's hard to find the most appropriate way to approach it. After all, physicians have been grappling with what one interview source called "frugal medicine" for what seems to be an eternity now.

But what we have done is turned our attention to the *efforts* being made by all parties involved in this problem — physicians, hospitals, third-party

payers, businesses and government. We have taken a look at what's being done, what has been done and what may be done in the future to control health care expenditures. Some of the methods are unique and innovative; others tried-and-true. Perhaps somewhere in their midst lies an answer . . . or the germination of one.

Next, we asked Robert White, MD, a Cleveland neurosurgeon who is deeply interested in biomedical ethics, to take a look at the moral and ethical questions being raised in the context of cutting costs in the health care arena. Will physicians ultimately be the ones who will have to decide whether quality medicine carries too high a price?

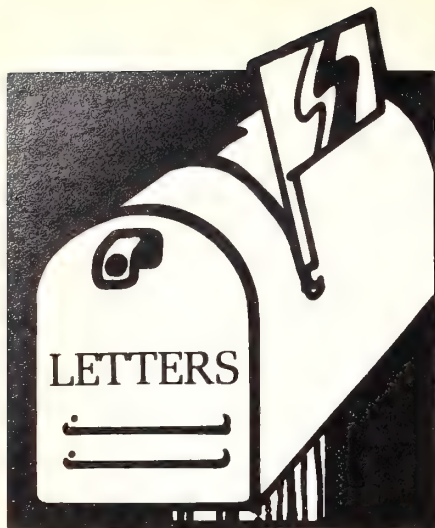
Medicine is changing, there's no question about that, and it's difficult to say right now which direction it will take. Can individual, fee-for-service practice continue to survive, or are we headed for a system of corporate medicine, where doctors will become nine-to-five, salaried employees?

You are the ones who may be responsible for the final decision. What you do now to cut costs may well direct the course of health-care delivery in the future.

Is time running out? Perhaps, when you come right down to it, you're the only one who can answer that. **OSMA**

— Karen S. Edwards





Letters ... to the editor

To the Editor:

I was quite impressed by the comments of Dr. Arnold J. Sattler, made in the "Letters to the Editor" column of the September *Journal*. I found three points, in particular, to be especially satisfying:

1. He referred to the article "Thoughts on the Nuclear Age" in the June issue as the "Final Epidemic" to which I heartily agree. Can preventive medicine be effective?

2. He quotes Victor Adler, a physician and an eminent Austrian politician at the turn of the century, "Medicine is health care for the individual; health care for the population-at-large is politics."

3. The unique background of Dr. Sattler.

Sincerely,
Roy H. Thompson, MD
Cleveland, Ohio

(The *OSMA Journal* welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.)

Patient information . . .

Recently, the Food and Drug Administration (FDA) enclosed a message concerning the proper use of prescription medication to 36 million Social Security recipients. The FDA took the action as a result of two FDA-sponsored surveys that suggested there was a low level of communication between patients and their doctors and pharmacists concerning prescription drugs. The message suggested that patients ask their doctors for the name of the drug and what it is supposed to do.

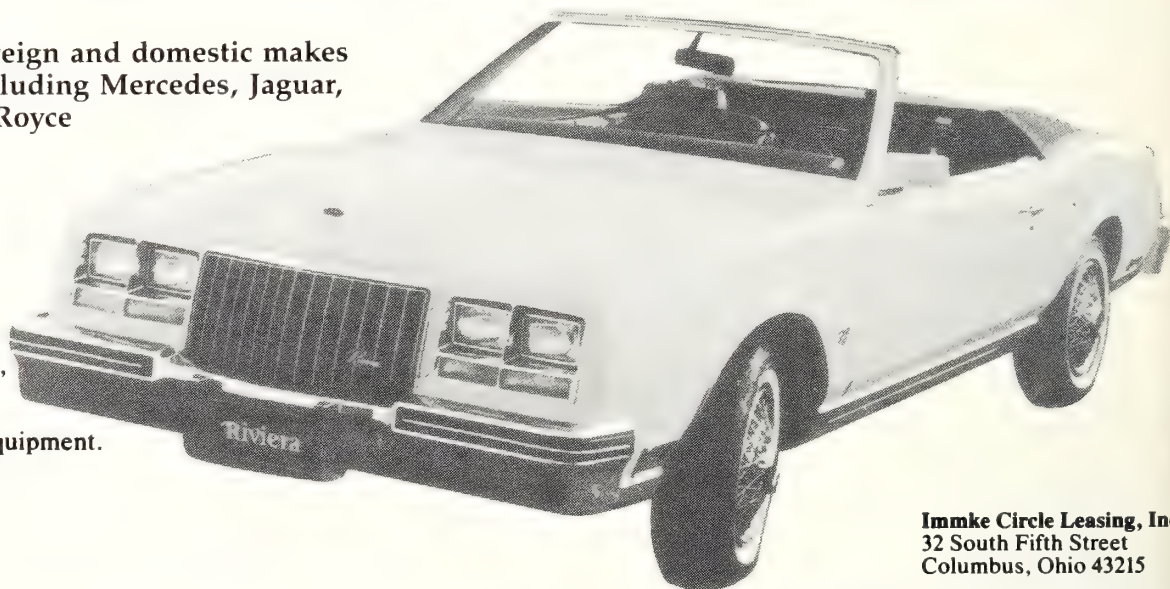
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Second Opinion

What's Really Behind Health Care Costs . . . and What We Should Be Doing About It

By John J. Newton, MD

Editor's Note:

The following text has been edited from a letter which Dr. Newton sent to the Honorable Marcy Kaptur, United States House of Representatives.

An attempt to hold the line at 10% must include denial of someone's care, which puts a great burden on those asked to do the denying.

Health care cost containment is a most complex issue, and I believe this complexity accounts for feelings of frustration in confronting it. It appears that the government began to pave the way for cost escalation with the Medicare Act in the 1960s. Over the years since then, the business community has continued in the same vein by allowing itself to be negotiated into a position whereby it pays for a large percentage of the health care that is utilized outside of the government system.

Over this period of time, since the mid 1960s, health care costs have been escalating on a rather steep curve. The

assumption has been that these rises in costs have been a result of the aforementioned actions by government and business. This may be partially true, but I suspect that it is far from the total explanation.

Another perception has been that the health care area has benefited greatly, economically, because of increased use of the system generated by the third-party payers. From this perception, the assumption has followed that the health care community is unwilling to address those issues honestly because of possible negative impact on its economic position. We maintain that this is a false assumption.

The feeling in the private sector has been that health care costs would be contained if insurance coverage were modified to include a cost factor that would impact the subscriber more directly, if hospital capital expenditures were rigidly controlled, and if "appropriate" utilization of existing facilities by physicians were instituted. It is certainly appropriate that these measures be adopted, but the likelihood of this adoption

resulting in the control of health care costs is highly questionable.

In my opinion, the real engine that is driving health care costs up is a combination of our aging population, rising technology, and a great demand for health care among the population. The population over age 65 annually uses approximately 4,000 hospital days per 1,000 subscribers; this compares to approximately 800 days annually of hospitalization per 1,000 subscribers for the population under age 65.

I'm sure you know as well as I the statistics regarding the average age of our population as we approach the year 2000. The increase in technology is a two-edged sword. Some may decrease costs, some may not affect costs, and some will increase costs. The issue of whether to regulate technology or produce it "on demand" has not been resolved — however, it's a complex issue, and we have to keep in mind that, historically, "regulation" has not always meant "best."

The main known (and probably the

continued on page 885

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What's Really Behind Health Care Costs . . .

continued

most strongly underestimated) is the real demand for health care. The public has an expectation that its health care needs must be met in a fashion that it has come to expect; that is, a physician or hospital may be enlisted when and as frequently as the consumer may desire. Some of this practice may be related to the fact that third-party coverage is available. However, part of the problem the HMOs have had is in teaching their patients to accept the fact that they may not need medical consultation on immediate demand. The public is apparently willing to spend its own money in order to have free access to the system.

One can see from the above that the situation is indeed complex. It is difficult to say what percentage of our gross national product should be devoted to health care. The growth of expenditures for medical care is a function of price and volume. To argue that the present percentage of the gross national product devoted to medical care is too great, is to assume that one knows the correct volume of medical care that should be consumed.

the decades ahead is very great. An attempt to hold the line at 10% must include denial of someone's care, which puts a great burden on those asked to do the denying.

If we are going to deal effectively with the health care issue in the future, we must begin facing the hard realities of supply and demand now. If we decide, as a society, that all medical knowledge and technology must be available to everyone, we must be willing to allocate greater and greater resources to this industry at the expense of other industries. If we are unwilling to do this, we must begin setting up the mechanism to make the difficult decisions that limit care. *Most importantly, we must recognize that this is what we are doing.*

In my opinion, all factions with an interest in health care costs must have appropriate access to the process and to the decision making if the best result — not only for controlling health care costs, but also for the most effective addressing of community health needs — is to be

the problem and some of its complexities. Obviously progress must be made in health care costs. Be assured that physicians as a group are much more willing to confront the issues in a constructive and conciliatory fashion than is presently recognized. **OSMA**

John J. Newton, MD, is Medical Director of the Alcoholism Treatment Center, Toledo Hospital, Toledo, Ohio.

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

If we are going to deal effectively with the health care issue in the future, we must begin facing the hard realities of supply and demand now.

In 1950, people in the United States spent more on alcohol and tobacco than on the entire health care system. We spent half again as much on health and education combined. Perhaps we are not spending too much for medical care today; but rather we were spending too little 30 years ago.

The truth, more likely, is that we did not have the knowledge or the technology to spend 10% of the gross national product on medical care in 1950. We probably would have if we had known how. If our society is beginning to feel that 10% of the gross national product is approaching the limit as to the resources it is willing to allocate to the health related activities, the potential for conflict in

achieved. These groups perforce would include (but not necessarily be limited to) the government, the business community, the labor community, hospital administrations, insurance carriers, the physician community and the hospital board community.

The sort of productive input that is essential is unlikely to be generated unless all views are heard. Someone has said that all of the actors on the health care stage must be heard, and all must hear the others in a setting that minimizes political confrontation and constituency rivalries and emphasizes the common stake in practical solution.

These thoughts are not mine alone, but I have tried to use them to outline

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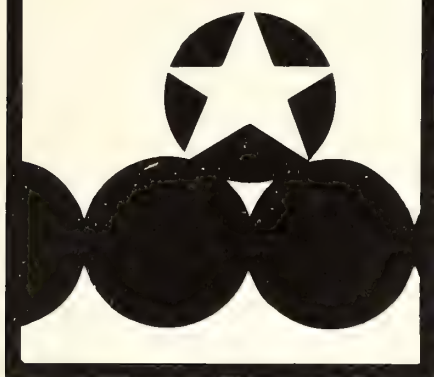
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Colleagues In The News



FRANK A. CEBUL, MD, Wooster, has been elected President of the Ohio division of the American Cancer Society. He will administer the \$12 million cancer control program for one year.

WILFRED B. DODGSON, MD, Youngstown, has accepted the position of Chief of Pediatrics at Youngstown Hospital. Dr. Dodgson is Director of Clinical Pediatrics and Neonatology and teaches medicine at Northeastern Ohio Universities College of Medicine.

CARL A. LINCKE, MD, Carrollton, was honored with a proclamation from the 115th Ohio General Assembly in recognition of his 52 years of service in the field of medicine.

EDWARD G. MANSOUR, MD, Cleveland, was elected Vice President of the Ohio division of the American Cancer Society. Dr. Mansour is the Director of Surgical Oncology at Cleveland Metropolitan Hospital.

WILLIAM A. MYERS, MD, Circleville, will be the new health commissioner for Pickaway County Health Department. He is the president of Circleville Associates Inc. and teaches medicine at Ohio State University.

JOHN H. ROSEMOND, JR., MD, Columbus, has been appointed to a three year term on the Board of Trustees at St. Anthony Hospital. Dr. Rosemond is the Chief of the Department of Family Practice at St. Anthony Hospital.

RICHARD D. RUPPERT, MD, Toledo, President of the Medical College at Toledo was elected to a three year term as trustee for the American Society of Internal Medicine. Dr. Ruppert last served as the vice chancellor of Health Affairs for the Ohio Board of Regents.

VICTOR A. SIMIELE, MD, Lancaster, was granted honorary, lifetime membership to the Ohio division of the American Cancer Society. Dr. Simiele has served the American Cancer Society for over thirty years.

ROBERT F. SYLVESTER, JR., MD, Newark, was selected by Governor Celeste to serve on the Ohio Recovery Council. The Council was formed by Governor Celeste to improve alcohol and drug abuse programs throughout the state. Dr. Sylvester also teaches medicine at the Ohio State University College of Medicine.

MANUEL TZAGOURNIS, MD, Columbus, dean of the College of Medicine at The Ohio State University, was recently appointed vice president for Health Services for the University. Dr. Tzagournis, a professor of medicine in the department of endocrinology and metabolism, has also served as assistant dean for research and continuing medical education for the college of medicine.

SYLVAN LEE WEINBERG, MD, Dayton, is the new president of the American College of Chest Physicians.

WILBURN H. WEDDINGTON, MD, Columbus, recently was named president-elect of the Ohio Academy of Family Physicians.

WILLIAM M. WELLS, MD, Newark, has been selected as Medical Director of Physicians Insurance Company of Ohio (PICO). Dr. Wells served as the president of the Ohio State Medical Association from 1977-1978.

JEROME F. WIOT, MD, Cincinnati, was recently elected President of the American College of Radiology. Dr. Wiot also is the President of the American Board of Radiology and serves as second vice president of the American Roentgen Ray Society, the oldest scientific radiological society in North America.

FREDERICK P. ZUSPAN, MD, Columbus, is the first recipient of the **RICHARD L. MEILING** chair in Obstetrics and Gynecology at the Ohio State University (OSU). The recipient of the chair is responsible for research in the development of human reproduction and its control, in maternal and neonatal health and in the heritage of gynecology. Dr. Zuspan is professor and chairman of obstetrics and gynecology at OSU, and is the past director of the American Board of Obstet-



Manuel Tzagournis, MD . . . new Vice President for Health Services



Richard L. Meiling, MD . . . honored by new chair in Obstetrics and Gynecology at Ohio State University



Jerome F. Wiot, MD . . . President of the American College of Radiology

rics and Gynecology. Dr. Meiling, after whom the Chair is named, is Professor Emeritus of Obstetrics and Gynecology at OSU and served as President of the Ohio State Medical Association from 1956 to 1957. Dr. Meiling was also a consulting medical editor for *The Ohio State Medical Journal*.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Susan Porter

Research center is state-of-the-art

State-of-the-art spectrometers, computers and data analyzers will be among those analytical instruments available to researchers at a new national center being established at Battelle's Columbus Division.

The \$5 million facility will be called the National Center for Biomedical Infrared Spectroscopy and will be used by Battelle scientists in conducting individual research programs, as well as in collaborating on programs with noted scientists and universities around the world.

The center's new sophisticated facilities will aid in the study and gathering of biomedical data at the molecular level. The data will be collected and stored on computers which also will perform spectral calculations and analysis functions.

Among topics to be researched will be the behavior of proteins such as enzymes or antibodies in solution, the identification of how synthetic materials used in artificial body parts interact with blood, and direct examination of the structures of the RNA component of cells.

The center is being established with a grant from the National Institutes of Health's Division of Resources.

Peer counseling improves prescribing practices

Physicians are most likely to listen to other physicians when it comes to prescribing drugs for their patients, according to a study conducted by researchers at Vanderbilt University. As a result, patients may benefit both physically and financially when doctors are counseled by other doctors to reassess their prescribing habits.

The report, published in a recent issue of the *Journal of the American Medical Association (JAMA)*, indicates that Tennessee physicians reduced their prescription writing practices by 50% for certain antibiotics after physician peers warned them of potentially adverse side effects. However, mailed brochures and visiting pharmacists giving the same information did not change physicians' prescribing habits.

Implications of the study are that there is a "need and desire of practicing physicians for relevant, convenient and unbiased sources of accurate prescribing information," says a Harvard Medical School physician in an accompanying editorial in *JAMA*.

Because pharmacology courses in



medical school are "rather brief to begin with" and because physicians must rely heavily on the promotional efforts of the pharmaceutical industry for subsequent information on drugs; there is a need for a clinical, science-based, noncommercial "detail person" to provide physicians with a continuing source of drug prescription information, the editorial concludes.

The patient knows best?

A lack of communication between physicians and their patients has been cited as a major reason patients are disobeying doctors' orders in a rising number of cases. And while some patients jeopardize their lives by refusing prescribed treatments, a significant number prove right to second guess their physicians, one study shows.

A recent report in the *Journal of the American Medical Association (JAMA)* indicates that as many as 20% of the patients in some hospitals initially refuse some form of treatment or diagnostic procedure ordered by their physicians.

The study was conducted by researchers at the University of Pittsburgh who looked at the behavior of patients in seven wards of four Pittsburgh hospitals.

One in nine patients in the medical

wards of the major teaching hospitals studied refused some form of treatment or diagnostic procedure each day, the study indicates. One out of 14 patients in the surgical wards turned down the ordered medical care.

Smaller community hospitals fared better, the study shows. There, one out of 25 patients ignored the advice of their physicians.

Although two deaths in the hospitals observed were directly linked to the patients' refusals to follow doctors' orders, in a significant number of other cases, the recommended treatments proved unnecessary, the study indicates.

In addition to poor communications, a growing public interest in the health care consumer movement was another reason given for this "patient revolt."

Reminders save time, money

Letter and telephone appointment reminders are among ways that physicians can save both time and money for themselves and for their patients, according to a recent report in the *Journal of the American Medical Association*.

The study, conducted by researchers at the Harvard Medical School, Boston, indicates that reminders reduced the "no show" rate for patients from 24% to 14% at a primary care center over a four week period. Also, contrary to previous studies, the reminders did not significantly increase the number of advanced cancellations.

With fewer unkept appointments, physicians are better assured of a more constant flow of patients; thus, the need for compensatory

overbooking decreases. Consequently, patient waiting time due to overbooking decreases, as well.

The study shows that telephoned and mailed reminders were equally effective in reducing no-show rates, and that the cost of both a manual letter and a telephone reminder is equal—about \$0.83 per patient. Computer-generated letter reminders proved even more cost-effective at an estimated cost of \$0.372 per letter.

Although about two-thirds of the savings realized by appointment reminders was generated from those patients (about 23% of the total) who have a no-show behavior, the researchers indicate that, "Even if some individual patients are less likely to miss an appointment, the effort required to recognize such patients is unlikely to be worthwhile. . . ."



Physician DRGs still under study

October 1 marked the beginning of the diagnosis-related group (DRG) system for Medicare reimbursements for hospitals throughout the nation. Whether or not physicians eventually will be paid according to that same system remains to be seen, although speculation is that the extension is inevitable.

However, officials from the Department of Health and Human Services (HHS), who have been directed by Congress to make a recommendation on physician DRGs by December 31, 1984, say the issue now is being given fair and objective study, according to a recent report in *American Medical News*. Roughly 60% of physicians' income would be affected by the DRG system if adopted, they say.

HHS officials in the Health Care Finance Administration currently are conducting a number of studies and collecting more data to determine not only the "feasibility" of physician DRGs but also their "advisability," according to Carolyn Davis, PhD, administrator HCFA. Data collected to date has not been sufficient to reach a conclusion, Davis said.

In addition to several new research studies, Davis also has instigated the

formation of an ad hoc group of physicians to lend input into the decision.

A DRG scheme for physicians could work in one of two ways, government officials reported at a recent AMA-sponsored meeting. Payments might be made to the physician as a part of a lump-sum payment to the hospital, or the physician might receive the entire payment and, in turn, have to pay the hospital.

American Medical News also listed the top 10 hospital DRGs in 1981, derived from the 1.95 million cases used as the base for the new Medicare payment system. Together, these top 10 accounted for 28.6% of all cases in that sample. They are, in order of frequency of occurrence:

- Heart failure plus shock.
- Esophagitis, gastroenteritis, plus miscellaneous digestive disease, patient older than 69 and/or complicating condition.
- Atherosclerosis, older than age 69, and/or complicating condition.
- Lens procedure.
- Chronic obstructive pulmonary disease.
- Specific cerebrovascular disorders, except transient ischemic attacks.
- Simple pneumonia plus pleurisy,

age older than 69, and/or complicating condition.

- Other disorders of the eye, age older than 17, with complicating condition.

- Circulatory disorders with acute myocardial infarction without cardiovascular complications, died alive.

- Diabetes, aged 36 or older.

Operation helps deaf

A rare operation performed recently at the University of Cincinnati Medical Center may offer hope for some severely deaf persons, as well as those with less severe hearing losses, according to physicians at that center.

The surgery was one of only 300 cochlear implants to be performed worldwide over the last 10 years. It consists of embedding an internal coil under the skin behind the ear and then placing an active electrode into the fluid which fills the cochlea. Two months later, the patient is fitted with an external coil which acts similar to a hearing aid. Together, the internal and external coils stimulate the inner-ear fluids and nerve fibers, creating the sensation of sound.

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Cost Effectiveness

The Cost-Conscious Physician

By Richard J. Nowak, MD

Health care has become expensive. National health expenditures have jumped from \$39 billion, which was 5.9% of the gross national product (GNP) in 1965, to approximately \$321 billion (10.5% of the GNP) in 1982. Government projections indicate that health expenditures will exceed \$750 billion (approximately 12% of the GNP) by 1990.

This is not necessarily leading to doom and destruction. The quality of medical care in the U.S. is superb. However, miraculous surgical procedures such as organ transplants and joint replacements, chemotherapy modalities for cancer, and other technological advances all cost money; and since these advances also increase the age of the population (who, in turn, require increased medical care), they are indirectly affecting health care costs in this country, as well.

Still, who is to say what percentage of the GNP should be used for health care? When your loved one needs that expensive, sophisticated treatment, medical device or surgery, who cares about health care costs?

The question is a difficult one to answer, but currently the response seems to be twofold: third-party

payers and the government care. After all, these are the groups paying those high medical bills, so perhaps the pressure they're placing on physicians to control spiraling health care costs is understandable. Yet, ironically, these

We, as physicians, must take the initiative in setting up the rules of our game. We can suggest where costs can be cut without risking the access to quality medical care we must insist on.

groups are as much to blame for the rise in costs as the inflation, which is still one of the most significant contributors.

In recent years, government and

private business have provided liberal health care benefits so broad and open-ended in scope, that many patients mistakenly perceive their medical care as being "free." As a result, a tremendous demand for medical services has been unleashed in this country — all of which is costing someone money, and, of course, that "someone" is the government and the third-party payers. Despite their role in the "cause" however, they are adamant about their part in the solution. They are insisting that physicians do what they can to cut costs.

And that is where we, as physicians, must assume a leadership role. We must take the initiative in setting up the rules of our game. We can suggest where costs can most opportunely be cut, without risking the access to quality medical care that we must insist on.

Examples of cost-cutting measures at work around the country are:

- Pre-admission testing, which saves the cost of a day in the hospital, prior to surgery.
- Ambulatory surgery.
- To Come In Surgery (TCI). Under

continued on page 895

An added complication... in the treatment of bacterial bronchitis*

Increasing incidence
of ampicillin resistance in
Haemophilus influenzae

Ampicillin Resistant
Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary Consult the package literature for prescribing information

Indications and Usage: Cefaclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindications: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins). Therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include symptomatic therapy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Cefaclor occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents (e.g., pressor amines, antihistamines, or corticosteroids).

Prolonged use of Cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematology studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-tape® (Glucose Enzymatic Test Strip, USP, Lilly). Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Use in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefaclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cefaclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

hour. The effect on nursing infants is not known. Caution should be exercised when Cefaclor® (cefaclor, Lilly) is administered to a nursing woman.

Use in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cefaclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthralgia and/or, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome. Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy include eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Clinical Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 17: 470, 1977.
3. Antimicrob. Agents Chemother., 12: 564, 1976.
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5. Current Chemotherapy (edited by W. Sengenthaler and R. L. Lilly), 11: 880, Washington, D.C.: American Society for Microbiology, 1976.
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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

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The Cost-Conscious Physician

continued

this cost-saving measure, the patient comes into the hospital on the morning of surgery, and is then admitted from the recovery room.

- Earlier discharges, which include immediate planning at the time of admission for transfer to a nursing home, long-term-care center, or hospice.

In the future, we may wish to pursue the following cost-cutting measures:

- Obtaining a more comprehensive history and top-notch physical exam of the patient before diagnosis — eliminating the need for complicated laboratory studies and expensive technological aids.
- Implementing an effective medical review program.

Here in Ohio, a number of progressive and foresighted physicians have already begun to take steps in the area of cutting health care costs.

For example, David Curtis, MD, of Toledo described a mechanism for underwriting health insurance benefits. The concept featured co-insurance delivery with a payback fund for unused benefits payable to the employee at retirement or termination of employment, with the goal that consumers would have an incentive to control their medical costs. A system similar to Dr. Curtis' suggestion was started about one year ago in Zanesville, Ohio with the Good Samaritan Hospital Employees Group (see March, 1983 *Journal*, "The Health Care Rebate.")

The real advantage of this system over the conventional insurance program is that, previously, employees felt they had to use their health insurance to get something out of it. Good Samaritan's "Stay Well" program rewards them with cash rebates if they use their benefits wisely. The hospital expects an employee rebate in excess of \$100,000 this year.

Edward Koster, MD, medical director of The Chevrolet-Toledo plant, recently sent out a letter suggesting ways to lower the cost of health care with regard to the length of hospital stay for elective admission. He suggests:

- Not admitting patients for those elective surgical procedures that could be done in outpatient facilities provided by most hospitals.
- Obtaining pre-admission laboratory and x-ray workups.
- Better communications between referring physicians and the specialist prior to hospital admission, so there is no lost time in the hospital setting.
- Not admitting patients for a diagnostic work-up.
- Not admitting patients on Fridays or Saturdays who must then sit around until Monday.

He also refers to the abuse of sick leave and states that prescriptions for restricted work activity could be given as a means of reducing this abuse. Dr. Koster's letter is the sort of advice which only leaders in medicine can

In April 1983, the Committee on Cost Effectiveness of the Ohio State Medical Association revised its purpose statement to read:

"Costs associated with obtaining quality medical care continue to burden the American public and elected government officials. Clearly, medical care cost increases are the primary issues our State and Federal governments face in the present economy.

"Ohio's physicians are expected to accept direct responsibility for addressing methods to make the costs of medical care reasonable to all patients and at the same time to take an active role in protecting against any efforts to lower the quality and accessibility of health care. Organized medicine is also expected to take innovative roles in developing cost-effective programs, with emphasis on

In health care's cost-cutting battles, physicians must be the first line of defense . . .

provide.

In another example, John Gibbs, MD, Chief of Staff at Toledo Hospital, has circulated a letter to the medical staff in regard to the notable increase in the number of laboratory, pharmacy, and radiology *stat* orders. In every case, these orders are more costly to process than regularly processed orders. For example, a laboratory *stat* order costs up to 40% more than a regularly processed order, particularly if the test involves both *stat* "draw" and *stat* "results."

A preliminary study by the medical audit department has indicated that many of the orders which have been labeled *stat* could have been processed as regular orders without any negative consequences for the patient.

These are only some of the ideas that have been initiated locally. Again, they demonstrate that **physicians must assume the task of manager, making conscious use of hospital facilities with cost effectiveness in mind.**

public education and the wise use of health care resources, coupled with physician education on the costs of services and their utilization. To be successful and to be able to demonstrate results, the OSMA must expand efforts throughout the Association to bring about answers which are acceptable to the Association's membership and the public it serves.

"This is no easy task, and will require great patience and skill of all who choose to accept the demand. The OSMA Cost Effectiveness Committee accepts the responsibility to serve as an appropriate vehicle to bring cost effective concepts to the attention of organized medicine. Some of these concepts may be accepted; some will not. Many will be ineffective; others will not do enough. But the effort will be made. The Cost Effectiveness Committee of the Ohio State Medical Association will devote

continued on page 905

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Arming the Future Physician for the Cost Battle

By Karen S. Edwards

If today's physicians are learning to become cost conscious through their own conscientious efforts, what about tomorrow's physician — the medical student who has a wealth of technology at his/her fingertips and yet lacks the experience to know what is the best, most cost-efficient treatment to prescribe? Is anything being done at the academic level to show tomorrow's physician the way to practice cost-efficient medicine?

As a matter of fact, yes. The AMA reports that more and more medical schools around the country are incorporating "cost awareness" programs into their curricula . . . and that includes some here in Ohio.

"What we are attempting to do is sensitize the students and house officers to the costs of health care. We want to make them aware of the issues," says William Sawyer, MD, Dean at Wright State University's College of Medicine in Dayton, Ohio.

Wright State's program is by no means unique. However, it is exemplary of the type of instruction medical schools are implementing to familiarize future physicians with the facts of soaring health care costs.

"We offer a formal, structured program to our first and second year students," says Dr. Sawyer. Course work (which is required at this level) includes:

- How health care dollars are spent
- The sources of health care dollars
- Methods of payment
- The health care market
- The allocation of resources by the medical market, and
- The "breakdown" of the medical market

"We actually define the different systems of health care delivery — the IPAs, the HMOs, and so on," says Dr. Sawyer, "so that our students become familiar with the systems, how they work, and their pros and cons."

The impact of diagnostic and treatment behavior on the cost of health care is discussed at the third and fourth year levels.

"At this stage, students are beginning to focus on clinical decision making," says Dr. Sawyer. It is here the students are taught to recognize the cost implications of diagnostic approaches and to focus, if possible, on cost-efficient alternatives.

"As members of patient-care teams, the students can not only apply these cost-effective concepts to actual decision-making, but they can observe the outcome as well," states Dr. Sawyer.

The lessons on cost containment for residents are less structured, less organized — "but they are still there," Dr. Sawyer emphasizes. Cost issues are brought up at patient rounds in a "hands-on" approach. Residents are given a chance to examine the hospital

continued on next page

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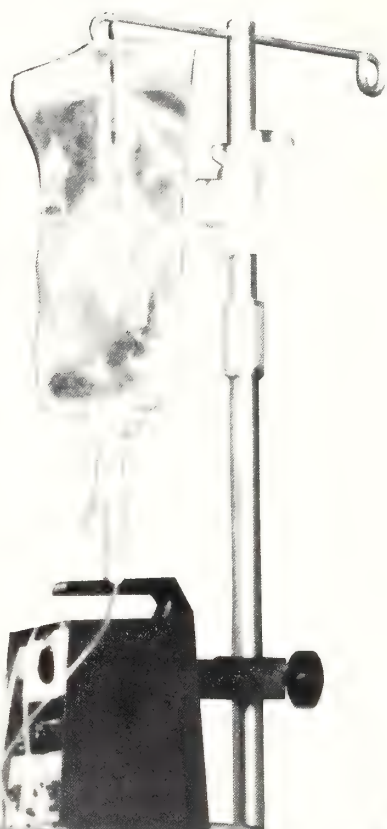
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Cost Effectiveness Education — A Student's Viewpoint

I asked several of my fellow medical students if they knew what a DRG was — or anything about the costs of medical care, in general. "No," was the most common response. One or two were informed about the economic issues, but only because of a special interest in these issues.

How is this ignorance possible, when economic turmoil is reshaping the practice of medicine? More importantly, what are we going to do to educate ourselves to these important changes in our future profession?

The limits to growth are here now, and further constraints will follow soon. Diagnosis Related Groups (DRGs) were imposed by the Federal Government on hospitals treating Medicare patients as of October 1 and may be applied to private practice by 1985. Big business has placed health care costs on its list of major concerns. Fortune 500 companies class health care as "an uncontrolled supplier" which they now want to limit. All of this, my fellow students, gives me plenty of motivation to incorporate cost effectiveness into my education — with or without a formal program in medical school.

Cost effectiveness doesn't dictate cutting corners. Cost effectiveness, according to Dr. Toni Eaton, "is the highest quality of medical care at reasonable costs." Some doctors feel that incorporating that philosophy into education may even improve quality.

In 1979, R.S. Lawrence stated that a typical medical student had limited knowledge of the costs of medical care and developed attitudes which placed undue emphasis on the indiscriminate use of diagnostic procedures. The ascribed reasons were a desire to establish a baseline and/or avoid litigation, as well as a lack of information on the costs of the tests. Furthermore, at one school, less than 50% of the clinical faculty could estimate cost to within plus or minus 25%!

Today, this most likely is still true. According to a 1982 General

Accounting Office report on cost effectiveness education, 90 out of 117 schools are providing cost containment training. However, only 61 out of 117 would report their hours (45% of which gave less than 20 hours, and only 5 schools over 100 hours.) The subjects most emphasized at these schools were: factors responsible for increasing costs, the physicians' role in generating costs, potential of physicians for controlling cost increase, benefit cost of diagnostic tests and of drugs, familiarization with costs of diagnostic tests, appropriate use of X-rays, relationship of quality and costs, and preventive medicine.

How do you learn about cost effectiveness? Like the practice of any skill, learning to implement cost control is a long-term endeavor of practice and refinement. Cost effectiveness encompasses cost facts, attitudes toward test ordering and hospitalization, philosophy (ie. the care of terminally ill), and common sense.

Information on costs has been taught via lectures, group discussions, rounds, clinical-pathology conferences, management conferences, peer reviews and chart audits at various schools and residency programs. The Medical College of Ohio, one of the pioneers in developing ways of teaching cost effectiveness, found that peer review exercises helped students realize the extent of overtesting and how to save costs by preadmission testing.

Several faculty suggest that cost effectiveness can be easily taught and have sustained effects on attitudes if it is related to the care of the patient, which indeed was a popular mode chosen by schools according to the GAO. Also concerning attitudes, Lawrence claimed that a measure of ambiguity and uncertainty in the decision-making process must be accepted. Medical education may not be helpful in controlling costs, unless students have more opportunities to learn from patients in an ambulatory setting. This means learning about

Arming Future Physicians

continued

bills of patients, audit the patients' charts for cost, participate in utilization review committees and review hospital charge lists.

All of this is enhanced for the resident, from time to time, by specific lectures or seminars on cost-containment. And, always, there is discussion — on both the application of cost-conscious medicine, and assessment of its effect on care.

"It's difficult to determine the success of our program," admits Dr. Sawyer, but in a survey of standardized examinations taken by residents across the country, Wright State medical students usually exceed the 90th percentile when answering questions based on cost related issues.

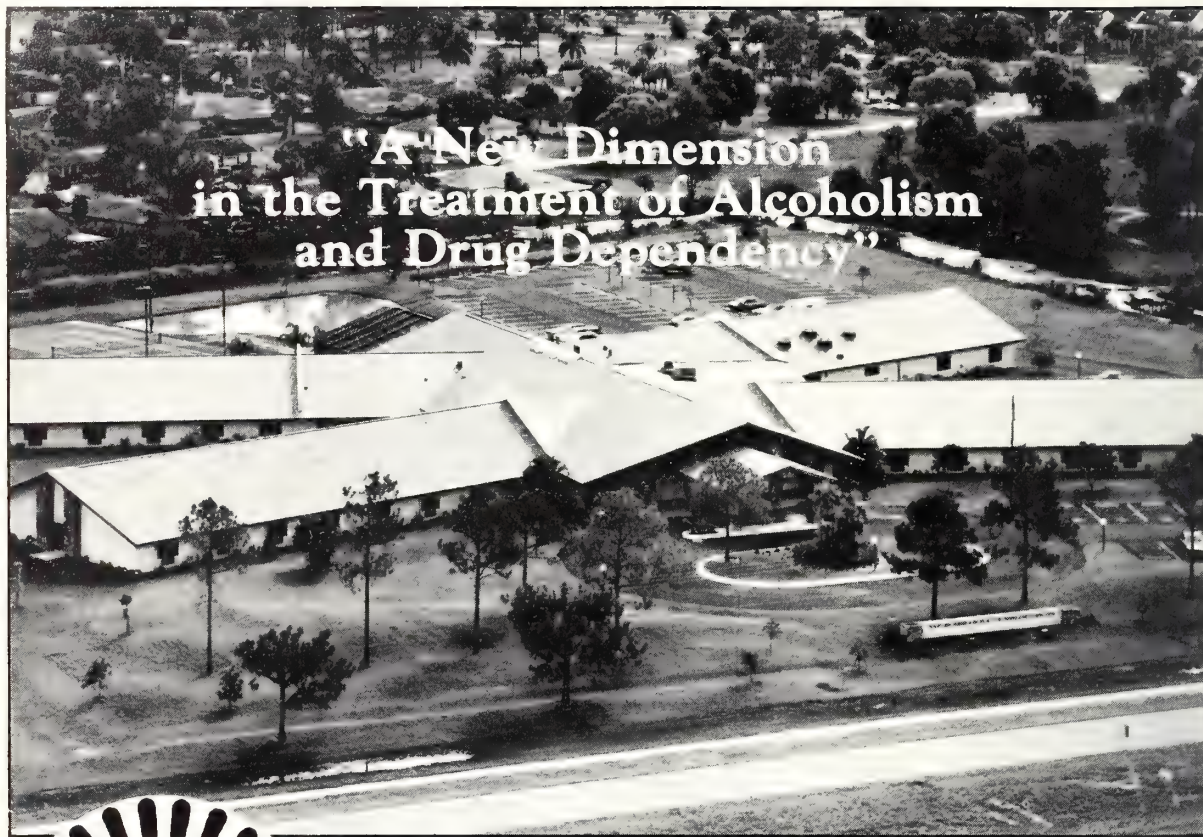
That fact has provided incentives for other departments in the school to launch similar cost awareness programs.

"The Department of Emergency Medicine is preparing a course for residents on 'Utilization of the Laboratory' which will stress ways to reduce the cost of quality care," Dr. Sawyer says, "and the Department of Psychiatry gives its residents an intensive administrative course which assumes they will be directly involved in the fiscal planning and budgeting of a department."

Such steps by medical schools have really become a necessity in these cost-conscious times. Without the kind of armament being supplied by such experienced and knowledgeable faculties all over the country, tomorrow's physician might very well lose the battle of trimming health care costs before he or she even begins to fight. **OSMA**

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.

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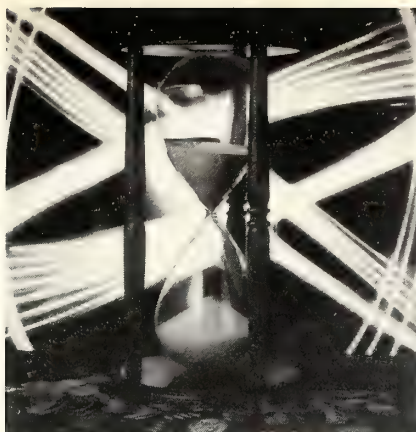
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Cost Effectiveness

What Hospitals Are Doing To Cut Health Care Costs

By Karen S. Edwards

Hospitals, like physicians, are caught between the proverbial "rock and a hard spot." Competition or regulation? Both may seem distasteful, but there may no longer be any other way.

In a recent newspaper column, humorist Erma Bombeck facetiously points out that if hospital rooms really cost as much as the bill indicates, she'd prefer to recuperate in a hotel room where, for the same price, she could enjoy a private room, color television with cable hook-ups, a continental breakfast (complete with newspaper) — and a night of uninterrupted slumber.

The problem may be a bit exaggerated, but the point is there. Hospital, like medical, costs have risen so dramatically in the past few years that people are taking a second look.

Certainly, the post World War II philosophy of equal access to medical care is partly to blame. There was a push to build and expand hospitals so that there would be enough adequate care for everyone. When new medical

gadgets were spawned, hospitals pounced on them without a second thought to duplication of effort.

Then, government came in and said "enough!" Health planning was mandated so that building and expanding slowed down. On their own, hospitals began to band together for "group purchasing" (reducing duplication of effort), and, for two or three years, they made a concerted "voluntary effort" to keep costs down.

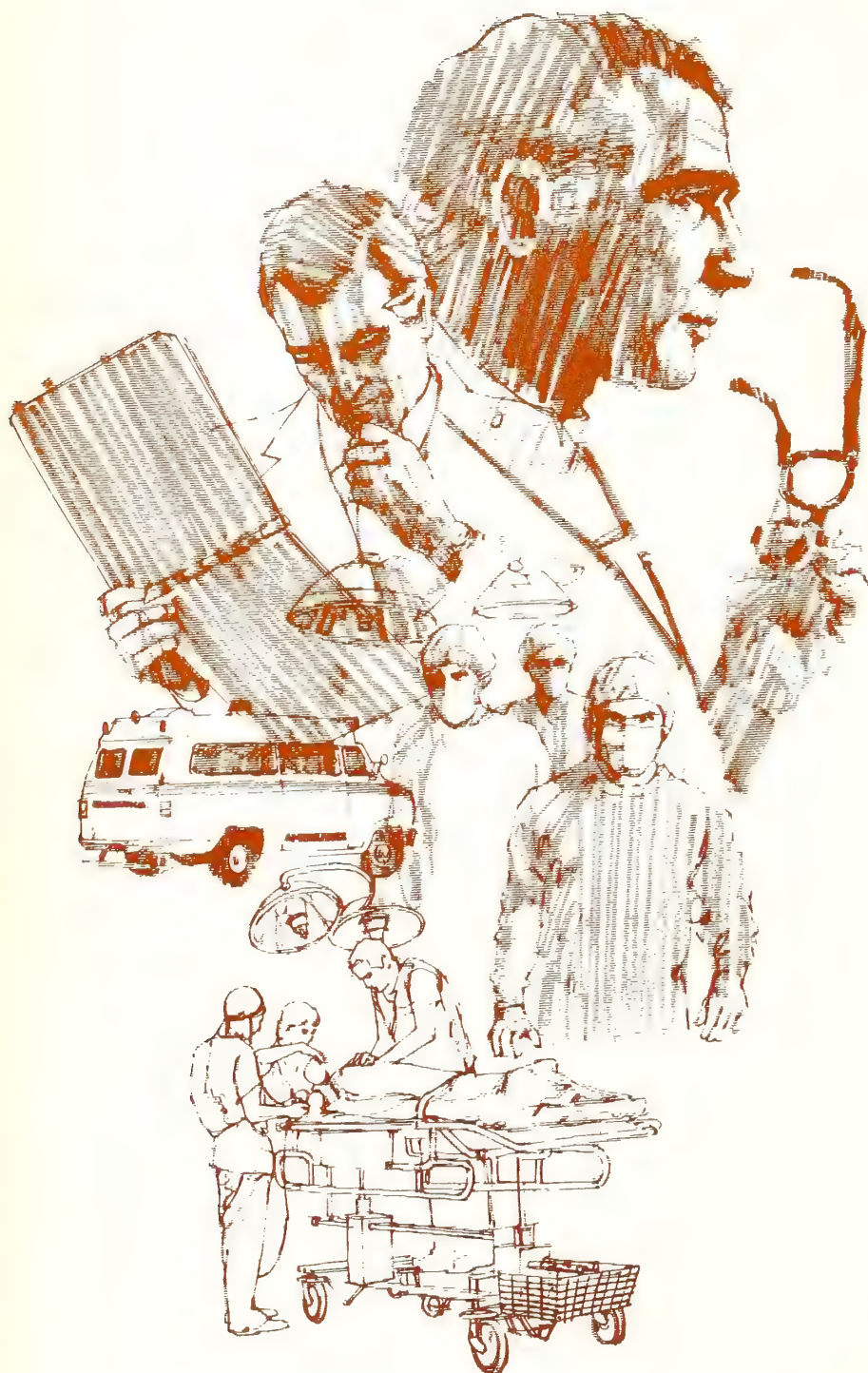
But costs wouldn't stay down — and, even now, continue to rise. (The costs of a hospital room rose to 13.3% of the Consumer Price Index [CPI], last year, the second largest increase behind health insurance which rose to 15.9%) This time, fingers are being pointed at insurance carriers who make it oh-so-easy for patients to obtain medical care — at whatever

price.

"At one time, patients would tell me they had to leave the hospital because they couldn't pay," says Frank J. Jirka, Jr., MD, President of the American Medical Association (AMA), in a recent article in the *Cincinnati Enquirer*. "Now, they ask how long they can stay because they have insurance. That attitude will have to change."

And change soon, because it doesn't appear that government is going to put up with increasing costs much longer. The Federal government has already implemented Diagnostic Related Groups (DRGs) in hospitals to reduce the amount of Medicare dollars it spends — and state regulatory measures may be close behind.

In fact, they may be nearer than
continued on next page



you think. Hospitals in six eastern states are already subject to a rate review system in which boards or commissions, named by the state, are given the authority to review all rates set by hospitals, as well as the hospitals' budgets. It's an idea that's creeping closer to home. Early this year, West Virginia passed a law establishing a Rate Setting Panel which will begin operation on July 1, 1984 — and Pennsylvania is considering similar measures. (Pennsylvania is so adamant about limiting hospital costs that it is not only considering regulating hospital rates, but exempting those hospitals which can meet cost containment goals.)

A similar bill is before the Ohio legislature now, although no indication has been made, yet, as to what the outcome might be. Rate regulation, however, is not the method most hospitals would choose to reduce costs. So what *are* hospitals doing to trim the bill?

The Voluntary Effort (VE), which was the Ohio Hospital Association's (OHA) sponsored project up until this year, did what it could to educate hospital staffs and patients to the problem of rising health care costs, and served as an incentive for hospitals to voluntarily contain their costs. Before the VE was disbanded, 37 Ohio hospitals were recognized by the OHA for outstanding efforts in the area of trimming costs.

Now, the AMA has started something new — the Economic Grand Rounds program — which, like the VE, has been designed to familiarize physicians (in this case) with the actual costs of hospital tests, procedures, etc. But there is an underlying purpose, as well.

"We are attempting to bring the physician and the hospital administrator together in their efforts to control costs," says a spokesman for the AMA's Department of Health Care Financing and Organization.

The project, which is in its initial phase, was launched in 87 hospitals across the country early this year. Two hospitals are in Ohio — Flower Hospital in Sylvania and Bellaire City

Hospital. According to the AMA spokesman, the response to the project has proven "very positive" to date.

"When we first started the project, some of the smaller hospitals admitted that it was rare for the administrators to sit down with the physicians on a project — and vice versa. But times are changing, and things simply aren't the same, in the traditional sense. There's a much greater need, now, for this kind of interaction," says the AMA spokesman.

"The grand rounds program is attempting to sensitize both physicians and hospitals to the cost problems going on right there in their own hospitals. We want to raise their consciousness.

"The economics of care is being incorporated into most medical school curricula (see related story), but the physician out there in private or hospital practice has been the one who has been most neglected. He or she really may not know the best way to cut costs. That's why we started this program," the AMA spokesman concludes.

"The 'smart' hospital will move into other areas of care, broadening its base and offsetting lowered Medicare patient payments, brought on by DRGs, with income from new services."

But the program is not without some criticism.

"With the advent of DRGs, the economic grand rounds, as we were initially administering it, has become passe," says Larry Lehner, Associate Administrator at Flower Hospital.

"When we first started the program it went like gang-busters. But our focus was on cost — putting a price on things — and with the DRGs, any discussion of price is really not relevant."

Wilmer Heceta, MD, who administers the program at Bellaire City Hospital, disagrees however. "The grand rounds program has a

major impact on DRGs" states Dr. Heceta, "because DRGs revolve around the issue of costs. Physicians are going to have to know the item-by-item, dollar breakdown of a case if they are going to successfully operate under the new system."

Lehner admits however that he is far from abandoning the project at Flower.

"Right now, it's in a holding pattern. We want to alter the course of the program so that it is presented in terms of utilization, not costs."

If regulation isn't what's wanted, and voluntary efforts no longer exist (or have become passe), what else is left?

There is really only one alternative — the same one that is open to physicians — competition.

"A trend that is definitely taking shape is the growth of multi-institutional hospitals," says Paul Feldstein, PhD, professor of hospital administration and economics at the University of Michigan, in a recent interview with *American Medical News*. "Hospitals will affiliate and

off the floor, and the rooms were renovated, with the intention of using them for patient overflow. Then, the rent-a-room idea struck, and it has been continuing ever since. The accommodations may not be comparable to the kind of luxury you get in first-class hotels, but for \$25 per night, the out-of-town spouse, or family member who wants to be nearby while the patient recuperates, gets a room with two conventional beds, a color TV, telephone and shower. An ice machine is down the hall, and guests are welcome to use the hospital's cafeteria, chapel and parking.

In a competitive marketplace, this is the kind of "smart" hospital that Feldstein says will survive.

So will St. John and West Shore Hospital in Westlake, Ohio. In order to meet the challenge of competition from special emergency care medical centers, their emergency room is offering a reduced rate for minor emergency room cases. A \$40 fee (\$30 less than previous charges) includes treatment for skin irritations and sore throats (which don't require a throat culture).

Certainly, a service of this type is fulfilling a need — but it also represents marketing — of a kind which is going to be seen in hospitals more and more.

It will be inevitable if hospitals want to survive. But the State may be ensuring competition, anyway.

This summer, a House Bill was introduced which would create a state agency to help consumers compare hospital costs. The idea behind the bill is to let the patients choose the least costly hospital for their needs. All hospitals would be required to post their charges for a variety of services — and, the theory goes, low bidder gets the patients.

The theory has a lot of holes — but it's an indication of where the cost-effectiveness battle is going.

Hospitals, like physicians, are caught between the proverbial "rock and a hard spot." Competition or regulation? Both may seem distasteful

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What Hospitals Are Doing to Cut Costs . . .

continued

to such traditional institutions as the hospital and the health-care profession as a whole, but there may no longer be any other way out of the restricting girdle placed on medicine by its prohibitive costs. Arguing for maintenance of the status quo is like matching wits with the Cheshire cat. You can say as much as you want, as loud as you want, but eventually the "status quo" is going to disappear. Soon there may be nothing left — save an infuriating grin. **OSMA**

Karen S. Edwards is the Executive Editor of the Journal.

The Cost-Conscious Physician

continued

its unified efforts toward evaluating on a continuing basis the concepts, plans, ideas and suggestions conceived by various government agencies, insurance carriers, health care coalitions, medical societies, and individual physicians, in a manner to weigh the value of their cost effectiveness and quality of care. Those with merit will be referred by the Committee to OSMA's Council for opinion and guidance."

In the past year, our committee has addressed many topics, including the health care of the elderly and the unemployed. We have used the *OSMA Journal* to educate the membership. We have discussed the guidelines on respiratory care, self

insurance, uniform insurance forms sponsored by Blue Shield and have heard testimony and received letters for review. "Project 83" for the unemployed in Cleveland and other areas of the state is a product of our discussions. However, it will only be with the help of high caliber physicians, such as those found in the OSMA, that our committee, and medicine in general, can hope to win the battle in containing costs and maintaining the high quality of medical care in the U.S. **OSMA**

Richard J. Nowak, MD, Cleveland, is Chairman of the OSMA's Cost Effectiveness Committee, and practices obstetrics and gynecology.

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Cost Effectiveness

What Third-Party Payers Are Doing to Contain Health Care Costs

By Susan Porter

Remember the scene from the movie "Network" where the frustrated newscaster, played by Peter Finch, goes on the air one night to declare to the world, "I'm mad as hell and I'm not going to take it anymore!"; then Finch manages to pass his feelings on to his TV news audience, to the point where everyone in the nation is sticking their heads out the window and shouting that statement?

This is the kind of frustration and anger that many of those in the business world currently are expressing over the high costs they now must pay for employee health care benefits. In turn, they are passing their frustrations along to the insurance companies, who are finding themselves in a similar pinch. And, together, they are warning both patients and providers that they're up to their necks in health care costs — "And we're not going to take it anymore!" — at least, not alone.

The reason for their frustration is understandable. In 1981 private insurance companies picked up the tab for some \$80 billion in health care costs, while the nation's largest insurer, Blue Cross/Blue Shield, paid out \$29 billion in health care claims. These carriers, in turn, passed those costs along to their clients in the form of higher premiums. Because business pays the largest percentage of those premiums as part of employee benefit

packages, it was employers who felt it most when the cost of health care rose at three times the rate of inflation last year.

All of this has occurred at a time when the nation's businesses are starting to pull out of a major economic recession — and at a time they can least afford another financial setback, says Charles Turner, director of the Coalition for Cost Effective Health Services in Central Ohio, one

For company stockholders, it means no dividends; for employees, it means no money for salary increases; and for consumers, it means higher price tags on the goods and services the company provides.

For instance, the total health care bill Chrysler will pay for its employees in 1983 will amount to more than \$600 for each car they sell, according to a speech given earlier this year by Joseph Califano, a member of the

For instance, the total health care bill Chrysler will pay for its employees in 1983 will amount to more than \$600 for each car they sell . . .

of numerous health action groups and coalitions that has sprung up throughout the state to help put a lid on health care costs. For one small Ohio company, for instance, premiums went up 80% last year, Turner says, while a 20% to 40% increase was not uncommon for Ohio businesses, large and small. "And if health care costs already represent 10% of your total budget, a 20% increase can flat out, wipe out your profits for the year," Turner points out.

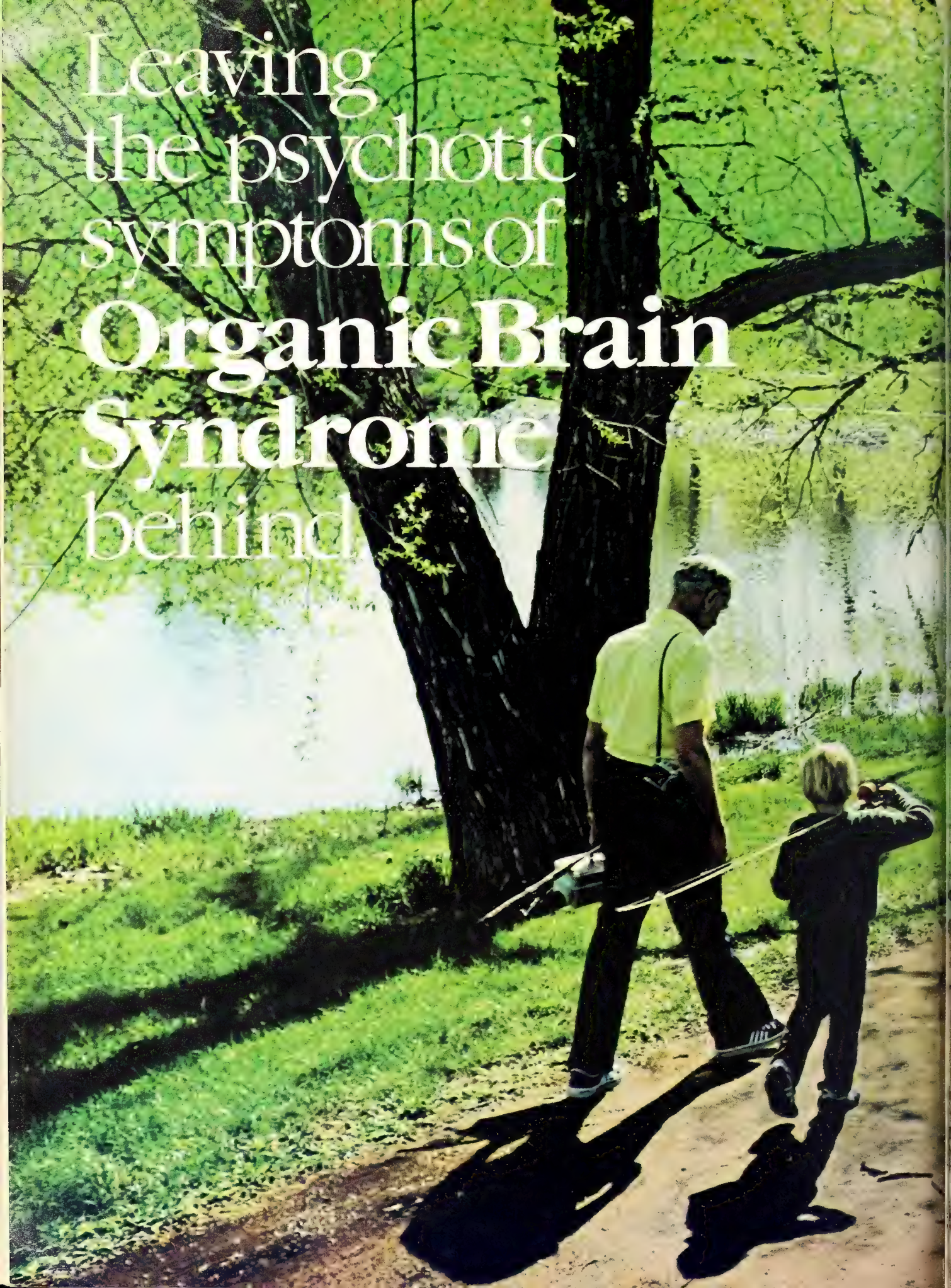
The company balance sheet is not all that suffers from such an increase.

board of directors of the Chrysler Corporation. This represents more than 10% of the sticker price on some of the lower-priced models, Califano pointed out. Multiply this cost factor by all of the other consumer goods and services purchased, and one realizes that the increased cost of health care benefits quickly becomes everyone's problem. And it may not be long before everyone in the nation is sticking their heads out their windows and making those same frustrating cries.

continued on page 911



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Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.

Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis, the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: Note: Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

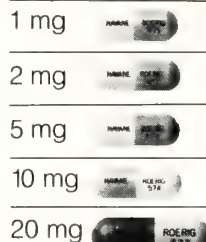
Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

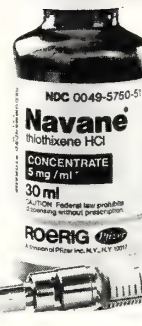
Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmic involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

Capsules
available in
5 strengths



Concentrate
5 mg/ml



Intramuscular
2 mg/ml
5 mg/ml



There is no known effective treatment for tardive dyskinesia, antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy. Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (i.e. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levaterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals

What Third Party Payers Are Doing to Cut Costs

continued

Patients, already, are beginning to feel the crunch more personally, as insurance companies design and businesses adopt new benefit packages that include larger deductibles and copayments, making employees share both in the risk and cost of health care. The primary impact of such "risk sharing" is that insurance premiums go down and the company saves money. But a second and more far-reaching result is that the employee is forced to become more involved in his/her health care planning and more responsible (financially and otherwise) for health care consumption.

"With first-dollar coverage, most employees don't know if the fee for a certain operation is \$300 or \$3,000, because they never see the bill," Turner says. "Many don't even know if their health insurance coverage is costing the company \$2.00 a month or \$200." Deductibles and copayments thus force employees to be more selective about the amount of coverage they are receiving and more skeptical about the health care treatment they need.

Benefit packages with hefty copayments and deductibles also provide companies with a lot more flexibility, enabling them to bargain with their employees on the "best" yet most "cost effective" means of receiving care. For instance, under some plans, employees are forced to "shop around" and may forfeit benefits or pay a high penalty if they fail to get a second opinion on an elective surgical procedure. On the other hand, they may get a decrease in their deductibles or copayments if they elect outpatient surgery instead of having an operation on an inpatient basis.

Procedures like preadmission certification for non-emergency hospital admissions and concurrent review while a patient is in the hospital are becoming common requirements for insurance reimbursements. And because most health insurance policies now include "medical necessity clauses" designed to weed out services rendered solely for

the convenience of the patient, some companies are practicing "retroactive denial" of reimbursements for treatments later deemed unnecessary by their own physician review panels.

In addition, both business groups and insurance companies are collecting data on physicians' fees in order to determine what is a "reasonable" and "customary" payment for a particular treatment or service. Through programs such as the Blue Shield "Advance Plan," participating physicians are reimbursed a set amount for a particular service rendered.

All of this means that, increasingly, physicians are being questioned and in some cases challenged on the decisions they are rendering for their patients and the fees they are charging for their services. And as business and insurance companies continue to adopt programs that require case review and encourage second opinions or

alternative forms of treatment, doctors can expect to spend more and more time explaining and tracking their actions, discussing alternatives with their patients and justifying their fee schedules.

Hospitals also are under careful scrutiny, as employers and insurance companies review and analyze claims to look for ways that money could be saved. Many insurance companies are becoming politically active, participating in the Certificate of Need process surrounding applications for hospital expansion and supporting legislation designed to regulate hospital charges.

Even patients are getting involved in the claims review process, as some companies ask their employees to monitor their bills in order to see if they are truly receiving all of the services for which they are being

continued on next page

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What Third Party Payers Are Doing to Cut Costs

continued

charged. Some companies using this procedure, says Turner, offer employees an added incentive for finding some mischarge — any money saved is split between the company and the employee.

Other "health incentive plans" offered by employers are designed to cut hospital stays to a minimum or to keep employees out of the hospital altogether. For instance, the Mannesman Demag Corporation in Cleveland offers women employees a \$200 bonus for a maternity stay of less than 72 hours. The Quaker Oats Company sets aside a \$300 fund for each employee, each year, to cover

the deductibles for health care use. If, at the end of the year, a balance remains, the monies can be used by the employee to purchase additional benefits or simply be withdrawn and spent as the employee sees fit.

Business and industry also are looking a lot more carefully at alternative health care delivery systems, such as HMOs, IPAs and PPOs, and are offering employees incentives to opt for these programs over traditional health care plans. Many larger employers, including the State of Ohio, have become self-insured, allowing them not only to reap interest off those monies not paid

out in premiums to the insurance companies, but also to create their own, custom-designed benefit packages. In some cases, non health-related benefits, such as daycare services, may be offered to employees as alternatives to traditional health insurance coverage.

Still, health care costs continue to rise, and many companies are to the point where, "They're ready to hand each of their employees \$1,000 a year and say, 'Here, go out and buy your own health insurance,'" Turner relates. "Many are wondering how in the world they ever got involved in all of this to begin with."

It is largely out of that kind of frustration that health action councils and coalitions have sprung up throughout the state in hopes of making a concerted effort to contain health care costs, says William Coleman, chairman of the Ohio Health Action Council and on the board of directors of the Health Action Council of Northeast Ohio. Groups from Cleveland, Ashtabula, Dayton, Toledo, Columbus, Mansfield, Springfield, Cincinnati and Akron are among those represented on the council, along with a number of large businesses and major corporations in the state.

Some of these groups are strictly business coalitions, representing only the interests of the business community, says Coleman. "But the majority, right now, are groups representing many parties concerned with rising health care costs, including the providers," he adds.

For example, the Coalition for Cost Effective Health Services in Columbus has taken a broad-based approach to contain health care costs. Two

Meditorial:

Why is it that the way to the hospital today is
you, but the way to the hospital tomorrow is
you, but the way to the hospital tomorrow is

The economic law of supply and demand still works. When you apply it to health care services, it works like this:

Price of services — Use of services — Health Care Costs

Anything that raises either price or use causes an increase in health care costs. If that continues unabated, even a vital necessity can eventually become an unaffordable luxury. None of us wants that to happen. But let's look at the pressures on prices.

Example: A neighborhood hospital just around the corner, is nice. But it may represent more facilities and services than the community needs and often operates with about the same range of services and the same number of people whether it's nearly full or half empty. Today, a number of hospitals are operating at far less than favorable capacity.

Result: Higher cost.
Example: Health service professionals want only the latest and finest equipment for you in your hospital, whether it gets full use or not. And with exploding technology, some of the most expensive equipment is out of date by the time it's installed. Now, if one electronic marvel which could have been shared by several hospitals is duplicated, instead, the obvious happens.

Result: High cost.

The health care cost equation isn't a hopeless dilemma. But it does call for judicious belt tightening. Consider this:

1. The number of patients in Central Ohio is basically static.
 2. More and more patients are being treated just as safely and carefully as before in less expensive settings.
- This makes the health care system more cost effective.

If there are more facilities and services than necessary, the new expenditures are not justified.

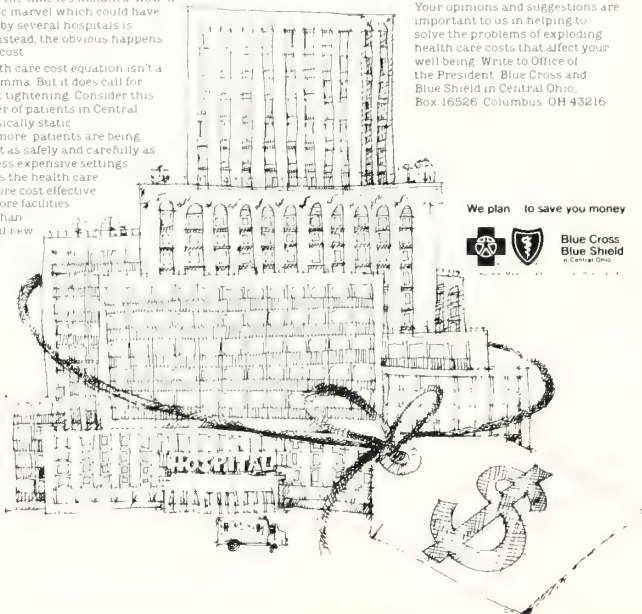
well served area, there simply won't be enough patients to go around. **Result:** Higher cost.

We work closely with medical and hospital professionals on reshaping patterns of care, emphasizing lower cost alternatives. And our combined efforts are working. But if supply exceeds necessary demand, and an under used facility or service continues to operate, then health care costs will continue to grow unnecessarily. So you see, the universal tendency to expand doesn't make sense. Instead, the system must work to consolidate facilities and services, or close them.

Identifying problems and exerting all the corrective measures we can is part of our job. And we explore every sensible option to help us do that job better. At the same time, we share the responsibility of squeezing the excesses out of health care costs with those who have a stake in the future of health care. And that's just about everybody.

What do you think? Do you agree that the time to control health care costs is not when you're on your way to the hospital, but when services and facilities are analyzed and planned? Your opinions and suggestions are important to us in helping to solve the problems of exploding health care costs that affect you well being. Write to Office of the President, Blue Cross and Blue Shield in Central Ohio, Box 16526, Columbus, OH 43216.

We plan to save you money



Left: An example of one of the paid advertisements which Blue Cross/Blue Shield is running in the print media.



The businessman has a right to decide how much of the bill that he will pay, just as I, the physician, have the right to charge what I feel is right . . ."

— Ronald Berggren, MD

physicians currently sit on its board of directors, and physicians serve on all but one of its many committees. "We are not a group of business people sitting around together and complaining about the providers," says Turner. "We sit down *with* the physicians and the hospitals and what we're trying to tell them is that *we* have a heck of a problem."

Ronald Berggren, MD, chairman of the OSMA Marketing and Competition Task Force and this year's president of the Academy of Medicine of Columbus and Franklin County, is among the physicians represented on the coalition. "The most important thing the coalition has been able to do, to date, is to open up the dialogue between the payers and the providers," Dr. Berggren says. "Today, I understand better what business is saying, and, likewise, business understands better what I am saying."

This has not always been the case, according to Dr. Berggren. "When the whole thing started out, I think business people were vehement. They wanted to 'go cheap' and to get the 'best buy' for their money. But as we talked about all of the problems surrounding health care costs and the added problems of cost shifting, they realized that the issue wasn't as simple as they were perceiving it."

Firing the blame at the health care providers has been a common

approach taken by insurance companies, as well. For example, Aetna Life and Casualty, one of the major providers of health care insurance in the state, launched major ad campaigns attacking both hospitals and physicians for the recent unprecedented increases in health care costs before shouldering some of the blame itself and admitting, "There is no single answer to the cost containment problem."

Likewise, Blue Cross/Blue Shield has taken a more educational approach to the subject. Through a series of "Meditorials" published in area newspapers, "the Blues" have gone directly to the public, asking clients as potential patients to be more cost-conscious in the decisions they make regarding health care.

"When you're on your way to the hospital, maybe you don't ask the price. But we do," reads one ad which calls for "judicious belt tightening" on the part of all involved. Another says, "You can't afford all the health care you can get." And still a third reads, "So, who says you need hospital care?"

Perhaps these statements sum up best the greatest efforts currently being made by both business and insurance to lower health care costs — making patients, as consumers, more aware, active, skeptical and more in control of the health care they both need and receive. And according to Dr.

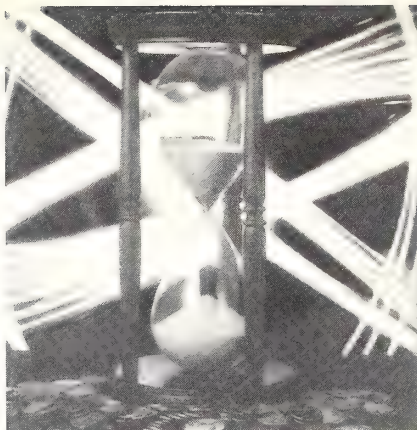
Berggren, that's exactly how it should be.

"The businessman has a right to decide how much of the bill that he will pay, just as I, the physician, have the right to charge what I feel is right to charge," Dr. Berggren says. "But the only person who has the right to deny treatment to a person is the patient. And if there's a problem with the money, then the doctor and the patient have to sit down and work it out."

Still, the physician remains the patients' chief advocate and top adviser, says Dr. Berggren, particularly where an issue of "quality" is involved, although the question of quality is a highly controversial and complex part of the cost-effectiveness issue — and one that cannot easily be answered, says Berggren.

"I think we, as physicians, have to be very open and honest with our patients, and yet not be too judgmental," he says. "Personally, I've been very impressed with my own patients. When given a choice, most of them make pretty intelligent decisions." **OSMA**

Susan Porter is Assistant Editor, the Ohio State Medical Journal.



Cost Effectiveness

What Government Is Doing To Cut Health Care Costs

By Eric Burkland and Susan Porter

Government's effort to curtail rising health care costs is no classified secret. Over the past several years, aggressive and well-publicized efforts have been made both at the state and federal levels to completely revamp those programs that fund health care for the nation's poor and elderly.

Today, government — chiefly through the Medicare program at the federal level and the Medicaid programs administered by the states — pays over 40% of the nation's health care bill. In 1971, federal, state and local tax dollars going for health care amounted to approximately \$36.1 billion. In 1981, that figure increased by nearly 400% to some \$122.5 billion. It is projected that by 1990, public tax dollars going for health care will amount to nearly \$325 billion.

In the State of Ohio, Medicaid costs increased over 700% between 1970 and 1981. Ohio Medicaid payments rose from \$115 million in 1970 to over \$1.2 billion in 1982, making Medicaid the most rapidly increasing expenditure item within the budget of the State of Ohio.

These dramatic increases, along with growing pressure from the private sector to contain health care costs, have brought the issue to the forefront

of political debate at all levels of government. And while, at first, there was a great deal of floundering as legislative leaders struggled to come up with short-term solutions to some long-range problems, current moves tend to be deft and swift and some heavy blows may be dealt the traditional practice of medicine before it's all over.

During the next 12 months, Ohioans will pay over \$12 billion dollars in hospital, doctor and other medical bills.

Federal Efforts to Reduce Costs

Over the years, the federal government's attitude towards rising health care costs — and all inflation — has waivered back and forth, from support of increased regulation and possibly a national health care insurance system, to decreased

regulation and the fostering of a more competitive, flexible, open system of health care delivery.

During the decade of the 1970s, political debate involved a centralized regulatory approach (leading to the development of regulatory programs such as health care planning, certificate-of-need and hospital rate commissions) focused on the national health insurance movement. Fiscal realities, as well as the results of the general election of 1980, effectively stalled the national health insurance movement and with it the centralized regulatory approach.

The current administration, on the other hand, has centered its approach to rising costs in all segments of the economy on the stimulation of free enterprise and competition. Yet at the same time, the past two years have seen the passage of the most stringent regulations for Medicare reimbursement since the program was initiated in 1967.

The first major changes came with the passage of the Federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which put a ceiling on the rising level of Medicare reimbursements. However, this system

continued on page 919



JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

Unique, once-daily formulation providing comprehensive cardiovascular protection

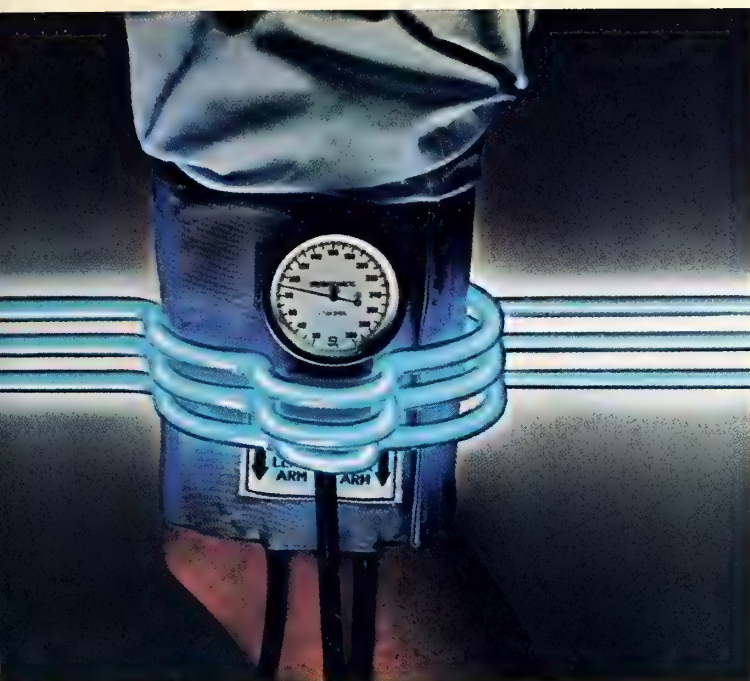
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL—with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



THE
ONE
TO COUNT ON

Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including **INDERAL** tablets, start with the nearest milligram equivalent of **INDERAL LA** once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional **INDERAL** (propranolol HCl) tablets.



80 mg



120 mg



160 mg

The appearance of **INDERAL LA** capsules is a registered trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

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INDERAL[®] LA

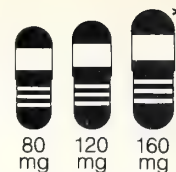
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Ayerst[®]

**The one to count on
for HYPERTENSION, ANGINA
and prevention of MIGRAINE.**

ONCE-DAILY

INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING
CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR)
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

Inderal LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

Inderal LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE.** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Inderal (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System. lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of Inderal LA capsules is a registered trademark of Ayerst Laboratories.

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What Government is Doing to Cut Costs

continued

recently was replaced with the newly implemented Diagnostic Related Group (DRG) prospective payment system which went into effect October 1 under the 1983 Amendments to the Social Security Act.

Some provisions of TEFRA remain intact, however. One is the way hospital-based or "provider-based" physicians are reimbursed for their services. Formerly, hospitals could pay their staff physicians whatever salaries they deemed proper and then pass this cost on to Medicare. Now, with some exceptions, provider-based physicians are reimbursed for services rendered to individual patients on the same kind of fee schedule assigned to community-based physicians working with Medicare patients.

Even more dramatic, however, is the DRG system which reimburses hospitals for Medicare patients according to 467 diagnostic categories. The system is currently being considered for physician Medicare reimbursement and may eventually be adopted at the state level for the Medicaid program.

Also under debate this past fall were some 38 proposals for changes to the Medicare and Medicaid programs made by the Health Subcommittees of the Committees on Ways and Means and on Energy and Commerce. Physician reimbursement and acceptance of assignment of Medicare patients was one topic of hot debate last October, which still had not been resolved as the *OSMA Journal* went to press.

State Efforts to Reduce Costs

"The cost of health care in the State of Ohio is increasing at the rate of half a million dollars a day, 365 days a year. It doubles every five years. During the next 12 months, Ohioans will pay over \$12 billion dollars in hospital, doctor and other medical bills."

So reads the opening statement of an "executive summary" issued by the Governor's Commission on Health Care Costs, dated July 8, 1983. The

task force was formed under Ohio Governor Richard Celeste late last winter during legislative deliberations on the state biennial budget. It was charged with the "task of developing strategies for the more efficient use of the state's health care resources and the reshaping of Ohio's health care delivery system."

Under the so-called "New Federalism," the states are seen as "laboratories of reform." As such, they may now seek waivers from the Department of Health and Human Services in order to implement certain cost containment activities.

The 44-member group met weekly for six weeks before coming up with an "interim report" of 24 recommendations issued June 29, 1983 at the end of the so-called "first phase" of the commission's work. An executive summary, which groups those recommendations into five categories, perhaps best spells out what may be in store for Ohio's Medicaid program:

"(1) *To create standards that are consistent with those of the Medicare program.* The Commission recommends that the State of Ohio adopt provisions of the Federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), placing a ceiling on the growth of hospital expenditures (per case), and limiting the compensation of hospital-based physicians.

"(2) *To make changes in the way the State pays for Medicaid services.* The Commission recommends that reimbursement levels be adjusted to encourage use of lower cost surgical settings, hospitals be required to create a multi-tiered outpatient facility fee structure, the State revise its long-term care reimbursement methodology, and the State speed-up hospital and nursing home audits. As a transitional measure, the Commission recommends a Diagnostic Related Group (DRG) prospective payment program for hospital services, to be implemented no later than July 1, 1984.

"(3) *To achieve appropriate use, quality control and efficiency in the delivery of health care services.* The Commission recommends pre-review of selected hospital admissions, certification of expected length of stay and concurrent utilization review, expansion of the Early Periodic Screening, Detection and Treatment Program for Medicaid-eligible children, development of a drug utilization review program, initiation of a pilot project related to pre-admission screening and nursing home applicants, revision of the ambulatory care and long-term care drug formularies, sending home unused medications with discharged nursing home patients (except when against physician orders), implementation of volume purchasing programs, and a crack down on provider and recipient abuse and fraud in the Medicaid program. As a transitional measure, the Commission recommends that the review of all certificate-of-need (CON) proposals and requests for determination of reviewability of projects be suspended until February 1, 1984, so that more appropriate criteria can be developed for future review.

"(4) *To expand alternative health care delivery systems.* The Commission recommends that the State encourage the expansion of health maintenance organizations

continued on next page

What Government is Doing to Cut Costs

continued

(HMOs), primary care and case management systems. In addition, it recommends two transitional/long-term initiatives: a pilot project to experiment with prospective payment for dental services, and the development of new regional capitated health plans. These changes in health care organization and finance hold great promise for future cost-effective management.

"(5) *To refinance the children's portion of the General Relief-Medical Program*, by adopting the Ribicoff children option under Medicaid. This recommendation will shift some health care costs from state and local governments to the federal government."

Omnibus Reconciliation Act of 1981

Of major importance in all of Ohio's attempts to reduce health care

costs is the Federal Omnibus Reconciliation Act of 1981 which gave the states the power to make major changes to their Medicaid Programs. Previously, the states could react to budgetary crises in two basic ways — reduce eligibility and/or covered services, or reduce the level of reimbursement to providers. The difficulties with both approaches are widely recognized.

Under the so-called "New Federalism," the states are seen as "laboratories of reform." As such, they may now seek waivers from the Department of Health and Human Services (HHS) in order to implement certain cost containment activities. Under the terms of the federal law, many states have moved rapidly to fundamentally restructure their Medicaid programs.

Here in Ohio, at the present time, the Medicaid policy debate appears to be focused on a generic "case management" concept. In a case management system, the patient chooses or is assigned to an approved primary care physician, group or administrative entity which acts as a kind of "gatekeeper." This gatekeeper is responsible for the overall medical care of that patient and must approve all diagnostic work, specialty referrals, hospitalizations, drugs, etc. Reimbursement methods vary, and the provider may or may not be financially at risk. Three very general financing and delivery models with the concept of case management have developed in the states: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Primary Care Networks.

Cost Effectiveness. A Medical Student's Views

continued

diagnosing the most probable cause of illness and about the doctor-patient relationship.

The ethical and philosophical relationships between medicine and costs are seldom addressed formally. According to Dr. Patrick Fahey, who offers a popular elective on cost effectiveness at the Ohio State University, topics such as treatment of the terminally ill might be discussed within the first year of medical school.

In closing, cost effectiveness is a topic students and residents must learn if they desire to operate a successful practice. If your school doesn't adequately teach the subject, you may have to actively pursue it on your own. As consumers with years of experience, as well as future physicians, the subject may not be as difficult as you think. **OSMA**
Clifford Eng, medical student member of OSMA's Cost Effectiveness committee.



photo courtesy of the Health Services Audio Visual Television center, the Ohio State University.

Next month in:

THE Ohio STATE Medical Journal

- **Medical legislation:**
The annual checkup
- **The New Ethics**

With organ transplants and the dilemma of Baby Doe, how are physicians expected to cope with a brand new set of ethics?

Meanwhile, the new year promises to be an interesting one, as the Governor's Task Force continues in "phase two" of its deliberations and takes a much closer look at a variety of other issues related to health care costs, including alternative delivery systems (licensure, Certificate of Need, payment, etc.); legal, insurance and financial bonding barriers to the establishment of PPOs and HMOs; new technology and services; excess health care capacity; hospital licensure and regulation; hospital rate commissions/all payer rate; health planning/re-establishment of HSAs; indigent care; workers' compensation; medical malpractice; long-term care reimbursement; state employee health benefits; data development/availability for health care users; and others.

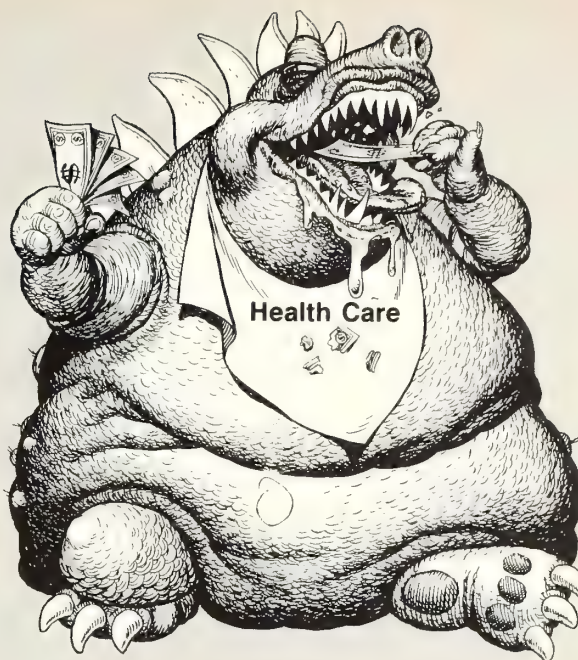
And if federal actions are any indication of what may eventually occur at the state level, 1984 will be a crucial year for health care financing in the State of Ohio.

Conclusion

In summary, government's impact on the cost of health care and the systems through which it is delivered goes beyond the Medicare and Medicaid programs and the 40% of the national health care budget government tax dollars support. As with all legislative policy, government sets the pattern for how inflation and rising health care costs will be handled by the private sector, and establishes the legal and regulatory terms under which the private sector may respond to its health care cost concerns.

Even more directly at stake is the issue of "cost shifting." Unless the rising cost of public sector health care is genuinely — not artificially — contained, government's new limitations on health care spending will do nothing more than push higher health care costs onto an already outraged private sector. As a result, the entire system of health care delivery and reimbursement in this country will be under fire, and no patient or provider will escape its ramifications. **OSMA**

Eric Burkland is Director of OSMA's Department of State Legislation. Susan Porter is Assistant Editor of the Journal.



The public's conception of health care, consuming larger and larger dollar amounts, has prompted many Americans to clamor for a change.

What Your Patients Are Saying About Health Care Costs:

America's health care system needs some major changes, and most Americans *are* willing to accept a broad range of measures to control health care costs. Those findings, revealed in a recent poll conducted by Louis Harris and Associates, Inc., may give some indication as to the next direction efforts to control rising health care costs may take.

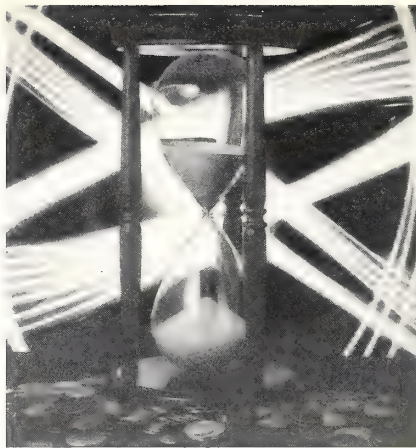
The poll, published in an issue of *Hospital Week*, found that, among the options most acceptable to the public for curbing rising health care costs are:

1. requiring second opinions for nonemergency surgery
2. encouraging that tests and minor surgery be performed in clinics and doctors' offices instead of hospitals
3. offering insurance plans with incentives to persons taking measures to promote their health
4. encouraging home care for the

chronically ill.

Significantly, many of the changes found acceptable to most Americans involved higher out-of-pocket expenditures for health care. Fifty-eight percent of those surveyed would accept higher deductibles than they now have in their insurance policies and 52% find it acceptable to require patients to pay a larger share of their medical expenses covered by health insurance.

Three-quarters of those surveyed believe the health care system needs major changes, and that view was shared by large majorities of employers, insurance executives and unions and by a marginal majority of hospital administrators. The one exception to this consensus was the group of physicians surveyed who generally believe the system works well.



Cost Effectiveness

The Costs of Prolonging Life

or can we afford the high cost of medical care?

By Robert J. White, MD, PhD

The public and, to some extent, even the medical profession itself are rapidly becoming convinced that health care costs are excessive. How could it be otherwise, for our local and national communicative media pours forth, almost on a daily basis, reams of financial and economic data purporting to demonstrate the gross inefficiencies and cost over-runs that characterize present day American medicine.

Overnight we seem to have suddenly created a staggering number of "Health Care Financial Experts" who, with almost religious fervor, are busily advising us on how to redesign our health care delivery system in order to assure appropriate fiscal responsibility. Of course, very few of these so-called "experts" have had

formal medical training or are directly responsible for patient care. As a consequence, they are ignorant of the most basic tenet of health care financing, which simply stated is: *to reduce medical care costs, one must reduce the quality and scope of that care.*

Nowhere is this concept better illustrated than at the leading edge of medicine, where Herculean efforts are made to preserve and prolong life within the framework of acute or chronic catastrophic illness. Thus, our federally supported End Stage Renal Disease program already costs in excess of \$1 billion per year; and estimates of the expense involved in developing a similar national program for heart transplantation, where five year postsurgical survival rates exceed

50%, would involve yearly outlays of over \$3 billion. An additional, often quoted, example in this area is that of the famous Mayo Clinic study, which argued that to add a year of life to a seriously ill patient, utilizing such super modern technologies as organ transplantation and renal dialysis, could cost as much as \$9 million!

While acknowledging the mega-costs associated with such advanced and even experimental biotechnologies as biological support systems (artificial heart) and organ transplantation (liver) to sustain life; the immediate, contemporary problem of the scope and quality of care as it relates to the prolongation of life in a cost-benefit sense already exists universally and with great frequency in our hospital

In the final analysis, the issue of health care costs and their containment is actually a moral one. Do we have the moral right to begin our reductions in the scope and quality of care to effect financial savings?

intensive care units. Here, highly trained personnel, utilizing the most sophisticated instrumentation and advanced pharmacology, manage both the young and the old following major surgical intervention or when suffering from overwhelming complications of disease.

Carefully designed studies have already documented that only a small fraction of our population yearly requires this form of intensive hospitalization, while at the same time demanding a disproportionately large share of financial expenditures in relation to all patients. Thus, the therapeutic management of patients within the hi-tech setting of the hospital intensive care unit is an expensive undertaking with the eventual clinical outcome frequently in doubt. Indeed, recently published reports strongly suggest that prognostic uncertainty is extremely high at the time of admission of such patients to these units and cannot be employed as a reliable guide to the allocation of these expensive resources.

Without question, the prolongation of human life within the clinical design of established American medicine is not only extremely expensive, but when examined in the cold light of cost-benefit analysis, frequently demonstrates an inverse relationship between cost and survival. Obviously, for these reasons as well as others, the high disproportionate costs of sustaining life in these specialized units with ultra-modern technology would seem ideally suited for examination and possible reduction. Unfortunately, in the process, we would have to acknowledge that our health care

system had reached a point of limited resources and could no longer afford the high cost of prolonging life in all of its clinical dimensions for everyone. As a consequence, we would have to begin selecting those patients who would be allotted these unique forms of treatment even while admitting our professional prognostic uncertainty as to potential survival in the total group.

And what of our biotechnological research programs — such as those dealing with the totally implantable mechanical heart and exotic organ transplants such as pancreas or brain — which hold promise for significant extension of life for some of us in the future, but at an incredible expense? Surely, these experimental undertakings, as well as others, would have to be eliminated or curtailed, for if we cannot afford the present hi-tech programs utilized to preserve life for all, how can we justify research to develop even more sophisticated and expensive techniques to prolong life for a few?

In the final analysis, the issue of health care costs and their containment is actually a moral one and is no better demonstrated than in the problem of the high cost of prolonging human life. For here, we have a small definable patient population, often hospitalized in a limited structural area (intensive care unit) and requiring enormously expensive outlays of medical resources. Do we have the moral right to begin our reductions in the scope and quality of care in this clinical microcosmos to effect financial savings?

Medicine's answer to this moral question should be a resounding, "No," for we seemingly cannot accept for economic reasons any compromise in the care of the desperately ill. The cost of appropriately and scientifically sustaining and prolonging life is high, but it must be accepted; otherwise, as physicians, we will fail in our ethical obligations and responsibilities to mankind. **OSMA**

Robert J. White, MD, is professor and co-chairman of neurosurgery at Case Western Reserve University, and director of neurosurgery at Cleveland Metropolitan General Hospital.



Let Synergy, the OSMA patient publication, help to answer your patient's general health and medical questions.

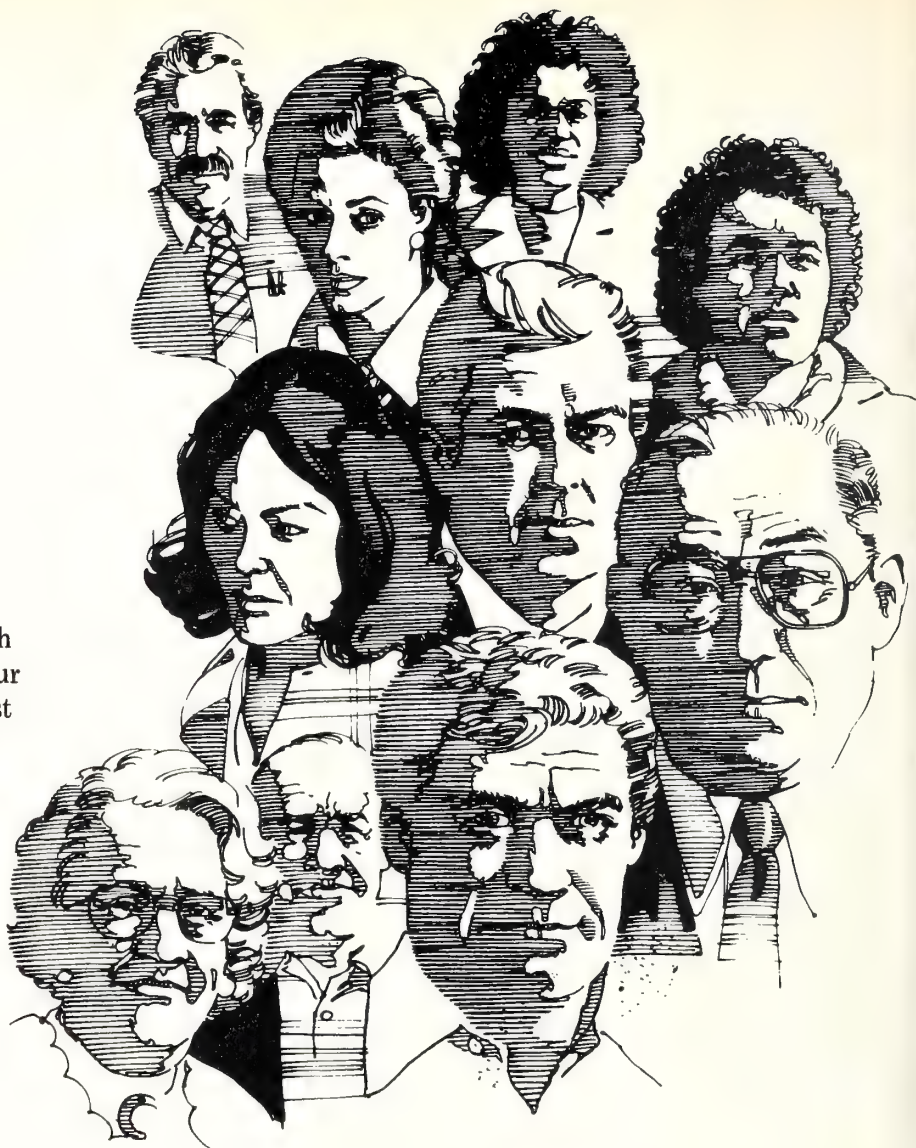
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INTRODUCING
THE

The word "ONE" is rendered in a large, bold, blue sans-serif font. The letter "O" is stylized with horizontal white stripes, giving it a nautical or flag-like appearance. The letters "N" and "E" are solid blue.

TO COUNT ON

NEW

ONCE-DAILY

INDERAL[®] LA

(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



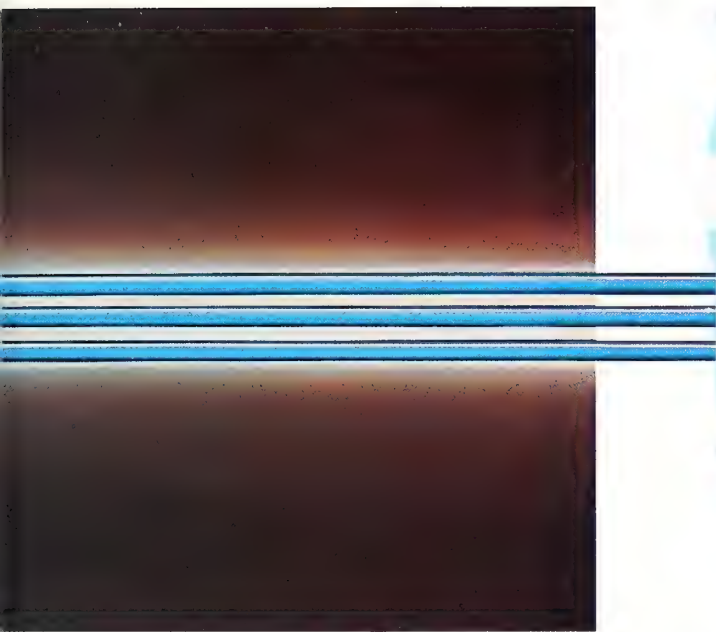
THE ONE
TO COUNT ON
FOR THE EXPERIENCE
OF INDERAL—

**A unique controlled-release
formulation offers effective
24-hour beta blockade**

Regardless of pH or contents in the GI tract, INDERAL is diffused from small spheroids at a controlled and predictable rate.

**Providing clinical results
equivalent to tablets**

In controlled clinical studies, a single daily dose of INDERAL LA provided the same therapeutic response as equivalent doses of conventional INDERAL tablets. While there is little correlation between plasma levels and clinical effect in hypertension and angina, blood levels achieved with INDERAL LA are usually lower than those achieved with an equivalent mg dosage of conventional INDERAL due to differences in hepatic metabolism.



THE
ONE
TO COUNT ON

WITH ONCE-DAILY DOSAGE

In hypertension, angina,
and migraine

Smooth 24-hour control

Unsurpassed simplicity
and convenience

Single daily dosage for
enhanced patient compliance

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



80 mg



120 mg



160 mg

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Ayerst Laboratories.

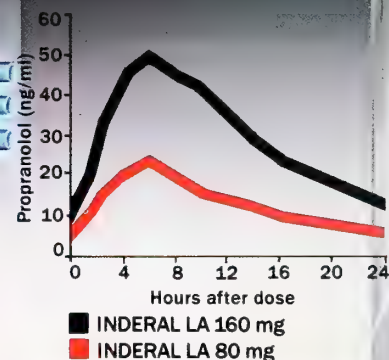
NEW

ONCE-DAILY

INDERAL[®] LA

(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

MEAN PLASMA LEVELS
ATTAINED WITH INDERAL LA
OVER 24 HOURS

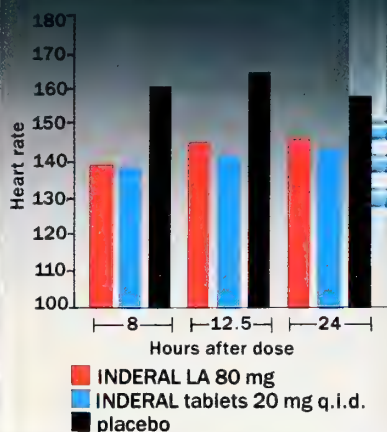


THE ONE
TO COUNT ON
FOR SMOOTH
PLASMA LEVELS—

Sustained plasma levels

In pharmacokinetic studies, blood levels with once-daily INDERAL LA were found to be adequate to maintain sustained clinical effect throughout 24 hours. The unique controlled-release formulation of INDERAL LA minimizes differences between peak and trough plasma concentrations.

**EFFECT ON POST-EXERCISE
HEART RATE OVER 24 HOURS***



AND 24-HOUR BETA BLOCKADE

**Provides therapeutic benefit
throughout the day and night**

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose—with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

ONCE-DAILY
INDERAL[®] LA
 (PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg



120 mg



160 mg

The appearance of INDERAL LA capsules is a trademark of Ayerst Laboratories.

*INDERAL LA vs. tablets: N.S. at all hours measured.

*INDERAL LA vs. placebo: $p < .05$ at all hours measured.

Please see last page for Brief Summary of Prescribing Information.

NEW
ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



THE ONE
TO COUNT ON
FOR INITIAL
THERAPY IN HYPERTENSION

Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

**Unsurpassed convenience
and simplicity**

Enhanced patient compliance



THE
CNE
TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of **INDERAL**

Like conventional **INDERAL** tablets, **INDERAL LA** should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES



80 mg

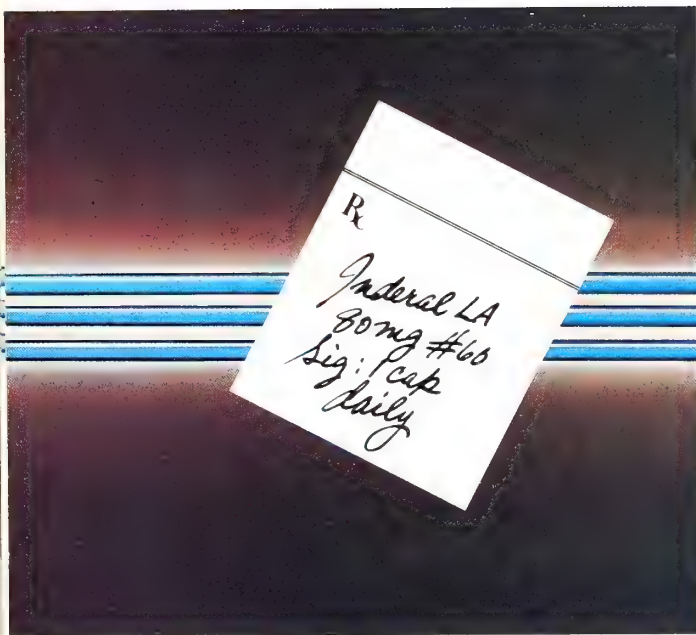


120 mg



160 mg

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THE
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TO COUNT ON

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COUNT ON FOR
THE EXPERIENCE
OF INDERAL
NOW WITH ONCE-
DAILY DOSAGE**

In hypertension, angina, and
migraine—start with 80 mg
once daily

Smooth 24-hour control

Unsurpassed simplicity and
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Enhanced patient compliance

Three strengths for prescribing
convenience

For arrhythmias, use
conventional INDERAL® tablets

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Please see last page for Brief Summary of Prescribing Information.

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG
ACTING
CAPSULES

ONCE-DAILY INDERAL[®] LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL[®] LA brand of propranolol hydrochloride (80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal, as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

HYPERthyroidism: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION – Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS – Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE – Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE.

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Hypnosis in Medicine: A Brief Overview

By Joseph J. Shorokey, William A. Price
and Simon W. Chiasson, MD

Editor's Note: In an attempt to create more clinical discussion in the Journal, several OSMA members were invited to read this article and to respond with any questions they may have regarding the points mentioned in the manuscript. Author Simon W. Chiasson, MD, has responded to the questions. Both questions and answers will follow the article.

Abstract

Hypnosis has enjoyed a varying status within the medical profession throughout the years. Today it is once again regaining popularity, with recent research demonstrating the usefulness of hypnosis in myriad conditions. Hypnosis can be a valuable adjunctive therapeutic tool in the wholistic care of patients. This article informs physicians of the many uses hypnosis has in medicine, surgery, obstetrics-gynecology, pediatrics and psychiatry. The uses of hypnosis in medical practice is endless, depending only on the physician's ingenuity and the willingness of the patient to accept this form of treatment.

Introduction

Hypnosis has been used in a variety of settings for many different purposes, but never has it had as many uses as it does today in the medical field. No longer can hypnosis be even remotely pictured as the

hocus-pocus sideshow attraction it once was with highway actors and con artists. Indeed, hypnosis has evolved from its early ancestry with Mesmer and Charcot to a legitimate and practical means of treatment in the medical field.

Regardless of the setting in which hypnosis is employed, its primary aim is to create an atmosphere of heightened suggestibility and acceptance of ideas more freely and enthusiastically than was possible before. Generally, 80% to 90% of the general population can experience a light trance, increased suggestibility, about 50% of these (40% to 45%) can experience a medium trance, and about 50% of those (20% to 25%) can experience a deep trance.¹ Since a light trance is all that is required to benefit most people, 80% to 90% of the population can be helped through hypnosis, making it an important therapeutic tool that physicians can employ. This article is an attempt to inform physicians of the many diverse uses hypnosis has in clinical practice.

Fear of Hypnosis

Because hypnosis often has been pictured as a mystical phenomenon or, worse yet, as a charlatan's hoax, many people have acquired false beliefs regarding it. Perhaps one of the most important barriers to overcome initially is the fear of hypnosis. Hypnosis should not be viewed as something to be feared, but rather as a useful and effective means of treatment. Many people fear the possibility of saying or doing something that is beyond their realm of control. This is not at all true, since the patient is fully aware of what is transpiring and would not do anything that would be thought of as immoral in the normal waking state.

Since the patient under hypnosis has an uncritical attitude and is highly suggestible, he/she may do things that normally would be repressed and fought against. Nevertheless, there is some reason to believe that there is a limit to the suggestions an individual

continued on next page

will accept even in the very deepest hypnotic state. The patient will not accept suggestions which are contrary to deep-seated ideas of moral behavior.²

Another barrier to hurdle is the fear of not being awakened. Some patients may believe that they will go so deep into a trance that the hypnotist will be unable to awaken them. There is really no chance of this occurring except in some abnormal cases where there might be a little difficulty in getting the individual to become un hypnotized.² This is, of course, a rarity and is usually only seen by staunch hypnotists and not by physicians who use hypnosis only occasionally in their medical practice.

Uses of Hypnosis

Hypnosis has recently undergone a rebirth in medicine with current literature revealing its usefulness in a myriad of settings. Hypnosis has proven to be an important adjunctive therapeutic tool when offering patients wholistic health care. Its uses in medicine, surgery, obstetrics and gynecology, pediatrics and psychiatry often overlap. This is only an indication of the flexibility that one may possess when employing hypnosis in clinical settings. The uses of hypnosis are endless, depending only on the ingenuity of the physician and the willingness of the patient to accept this means of therapy.

Hypnosis in Medicine. — The relief of pain has been one of the major uses of hypnosis. It has been used to treat the pain of terminally ill cancer patients and burn patients³ as well as treating migraine and tension headaches,⁴ and chronic back pain.

Hypnosis has also proven quite useful in increasing the inner strength or will to live in terminally ill patients. By improving a patient's emotional and physical self concept, the quality of life can also be improved.

Hypnosis can be an important adjunctive therapeutic device in reducing blood pressure in hypertensive patients.⁵ It can also play an important role in a multi-modal approach to dealing with addictive behaviors such as overeating,⁶

smoking⁷ and alcohol abuse.⁸

Finally, hypnosis has been used in such diverse areas as treating dermatologic problems and warts.⁹

Hypnosis in Surgery. — Hypnosis is an effective means of producing anesthesia without the use of chemical agents.¹⁰ By employing hypnosis instead of the chemical approach to deaden pain, the physician can spare the patient unnecessary side effects and allow the patient a clearer mind.

Anesthesiologists who use hypnotherapy also have noted that patients often respond in the post-operative period to suggestions given during or following anesthesia. Such suggestions include: reducing bleeding, absence of nausea, reestablishment of peristalsis and bladder function and rapid healing.¹¹

Hypnosis in Obstetrics/Gynecology. — Medical hypnosis is an ideal form of analgesia and anesthesia in obstetrics.¹² Not only does it spare the mother the unnecessary side effects of the medications employed, but hypnosis has the added benefit of sparing the baby these deleterious effects also.

Hypnosis has a great deal to offer in obstetrics by treating hyperemesis gravidarum,¹³ inducing labor, producing anesthesia during delivery and afterwards and reducing the anxiety that the mother may experience. In gynecology, hypnosis can be used to reduce the anxiety that often accompanies pelvic exams.¹⁴ Hypnotherapy can help to relieve this anxiety and make the whole experience more pleasant and much easier.

Another area where hypnosis appears to be exceptionally promising is in the treatment of sexual dysfunction. Hypnosis has proven to be quite useful in the treatment of vaginismus, preorgasmia and frigidity in women, while also being used to treat pre-ejaculation and impotence in men.¹⁵

Hypnosis in Pediatrics. — Children are better adapted for hypnosis than adults because they are willing to accept what the hypnotist is saying

more freely and without judgment. Hypnosis has been especially helpful in pediatrics where it has been used successfully in treating asthma, enuresis, functional megacolon, migraine headaches and burns.¹⁶

Hypnosis also can be successfully employed to relieve the fear and anxiety that often accompanies overnight visits to the hospital or minor procedures. It can decrease the trauma experienced by young children who often must be strapped down or literally held down by bodily force in order to perform a procedure that otherwise would not cause any problems. Hypnosis can also spare children the side effects that accompany many medications.

Hypnosis in Psychiatry. — Using hypnosis in psychiatry usually requires extra training in order to assist the patient in achieving a deep trance and delving into the unconscious and its repressed thoughts. Generally, it is those who suffer from neurotic illness with all its manifestations who can be helped the most with hypnotherapy.¹⁷

Hypnosis is also useful in dealing with personality problems such as: addictions, anorexia and eating problems, immature personality and problems of adolescence. A variety of psychosexual problems can also be treated with hypnosis. One group of patients — those suffering from florid psychosis — should be treated with the appropriate medication and supportive psychotherapy and not with hypnosis because the hypnotic suggestions may cause an unwanted response.¹⁷

Conclusion

Hypnosis is a valuable, but underused medical tool capable of relieving pain and anxiety, increasing compliance with medical regimens and facilitating normal physiologic functioning. Since 1958, when the American Medical Association determined that hypnosis had a recognized place in medicine, its acceptance and use has grown considerably.

Classes and seminars now exist where practicing physicians, residents

and medical students can gain the knowledge and skills necessary to employ hypnosis for the benefit of others. Instruction on hypnosis is available throughout the country, beginning at a basic level of learning induction techniques and progressing to a highly skilled level of specific therapeutic interventions. **OSMA**

Discussion of article follows on next page

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Discussion

Hypnosis in Medicine: A Brief Overview

Q. What are some problems of adolescence for which hypnosis is used as a treatment?

A. Some problems of adolescence that hypnosis is used in treating:

1. Psychological disorders
 - a. Behavior disorders
delinquent behavior, rebellion at home or at school, poor self-control, and tantrum behavior
 - b. Anxiety disorder
 - c. Phobic reactions
 1. school phobia
 2. needle phobia
 3. animal phobia
 - d. Post traumatic psychogenic amnesia
 - e. Sleep disorders
 1. nightmares, night terrors
 - f. Social anxiety
 - g. Somatoform disorders
 1. conversion reactions
 2. psychogenic seizures
 3. psychogenic pain
 4. anorexia nervosa
 5. autism
2. Habit disorders
 - a. Enuresis
 - b. Soiling
 - c. Speech and voice problems
 1. stuttering
 2. defects of articulation
 3. voice problems
 - d. Intractable cough
 - e. Intractable hiccups
 - f. Giggle micurition
 - g. Hair pulling, nail biting, thumb sucking
 - h. Sleep walking
 - i. Chronic overeating
 - j. Tics & Tremors

- k. Habitual drug abuse
3. Hypnotherapy for problems in learning and performance

Q. What is the success rate of hypnosis versus other modalities in the treatment of enuresis?

A. Hypnosis works much better than most methods for enuresis. Older children usually do well after one or two visits. Younger children may require return visits every two weeks for several visits.

Q. What characteristics of a pediatric patient would one consider in deciding whether hypnosis should be employed? At what age?

A. Age hypnotizability limited in young children, increases markedly from 7-14 and then decreases somewhat in adolescence. Many children do respond to hypnotherapy, and many reports conclude that the crucial element in treatment is hypnosis and not something else. In a field of the art where the state of the art is not as primitive as in child hypnosis, such an argument would, at best, be considered very weak. In this field it seems to be the only reasonable place to stand for the time being.

Q. Cannot "unnecessary side effects" brought on by conventional methods of pain relief be most

often controlled, or in fact be eliminated by a skilled physician?

A. Yes

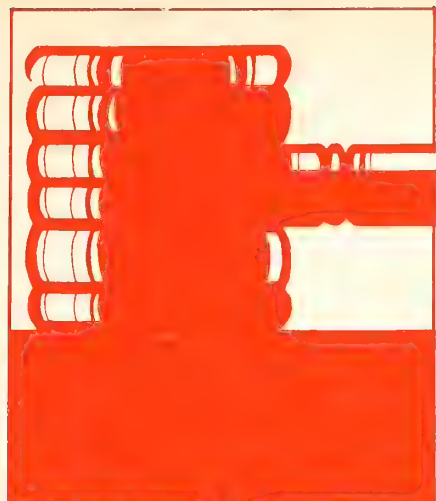
Q. What are the deleterious effects on the body from medicating the pregnant mother?

A. It is not the effects on the body but the effects on the baby inside of the uterus, i.e.

- a. Drugs for nausea causing possible malformations
- b. Aspirin can cause bleeding tendencies in baby
- c. Cigarettes can cause carbon monoxide build up in mother and limit oxygen to baby and by constricting the peripheral vessels cut down on exchange of O₂ and CO₂ and nutrition and waste products through placenta.
- d. Using podophyllin for condyloma can cause toxicity in the mother
- e. Using fluid pills can theoretically cause bleeding tendencies in infant

Q. What are the adverse effects of hypnosis? What about a bungled attempt by an inadequately trained person?

continued on page 947



council proceedings

September 9-11, 1983

A regular meeting of the Council of the Ohio State Medical Association was held Friday evening, September 9; Saturday morning, September 10 and Sunday morning, September 11, at the OSMA Headquarters Office, Columbus, Ohio.

Those present for the Friday and Saturday sessions were: S. Baird Pfahl, Jr., MD, Sandusky; C. Douglass Ford, MD, Toledo; David A. Barr, MD, Lima; John E. Albers, MD, Cincinnati; Herman I. Abromowitz, MD, Dayton; Thomas R. Leech, MD, Lima; Benjamin H. Reed, MD, Wauseon; Donavin A. Baumgartner, Jr., MD, Cleveland; J. James Anderson, MD, Youngstown; H. Judson Reamy, MD, New Philadelphia; Carl E. Spragg, MD, New Concord; Thomas P. Price, Jr., MD, Gallipolis; D. James Hickson, MD, Mt. Gilead; D. Ross Irons, MD, Bellevue; Joseph L. Kloss, MD, Akron; Stella Brown, Dayton, President, OSMA Auxiliary; Oscar W. Clarke, MD, Gallipolis, Chairman, AMA Delegation.

Those present for the Saturday session only were: Donald R. Goodwin, Senior Vice President, PICO; David W. Pennington, President, PACO; David L. Jackson, MD, Columbus, Director, Ohio Department of Health; William H. Gates, MD, Cincinnati, Chairman, OSMA Emergency and Disaster Medical Care Committee.

Those present for the Sunday session were: Drs. Pfahl, Ford, Barr, Abromowitz, Leech, Reed,

Baumgartner, Anderson, Spragg, Price, Hickson, Irons, and Alan T. Mong, Columbus, President, Medical Student Section.

Those present from the OSMA staff were:

Friday — Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Gail E. Dodson; David C. Torrens; Carol W. Mullinax; Eric Burkland; Michael L. Bateson; Louis N. Saslaw; Aristotle Hutras; Carol Maddy; Susan Porter; Ginny Strawser.

Saturday — Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Robert E. Holcomb; David C. Torrens; Gail E. Dodson; Carol W. Mullinax; Michael L. Bateson; Louis N. Saslaw; Aristotle Hutras; Carol Maddy.

Sunday — Hart F. Page, CAE; Herbert E. Gillen; D. Brent Mulgrew, Esq.; Michael L. Bateson; Aristotle Hutras; Gail E. Dodson; Katherine E. Wisse.

The Council acknowledged a note from Mrs. Pfahl with regard to the Councilors' expression of appreciation for the reception and dinner for the Council and guests held at the Pfahl home, July 16.

The Nominating Committee of Physicians Insurance Company of Ohio reported its recommendation that Dr. Pfahl be elected as a Class "A" Director of PICO, to succeed Dr. William M. Wells, Newark, who has resigned from the Board.

Announcements by President Pfahl

Dr. Pfahl announced the birth of Michael Timothy Costello, whose parents are Daniel and Catherine Costello, the latter being OSMA Associate Staff Counsel. The Council voted to welcome Michael Timothy to the OSMA family.

STATE ISSUES #2 AND #3

Dr. Pfahl reported on a telephone call received by him from Governor Celeste with regard to State Issues 2 and 3, on the Ohio statewide ballot in November.

Mr. Page discussed a similar call, which he received from House Speaker Vern Riffe.

Mr. Burkland reported on discussions with other associations and with key members of the House and Senate.

The Council voted to take no position on Issues 2 and 3.

The Council suggested the position of the Council and the arguments for and against both issues be discussed in the OSMAgram with directions for the contribution of funds to committees for either cause, whichever the member selects.

Administration

The minutes of the July 15-17, 1983 meeting of the Council were **approved**. The Executive Director presented his report.

He introduced Ginny Strawser, new editor of *Synergy* and Susan Porter, new assistant editor of the *Journal*.

Physicians Administrative Corporation of Ohio (PACO)

Mr. Pennington and Dr. Abromowitz reported on the progress of PACO.

Financial and Membership Department

Mrs. Wisse presented membership statistics indicating that paid membership has exceeded the December 31, 1982 record membership and that total membership passed the 17,000 mark.

Dr. Barr presented the Treasurer's report and reviewed interest rates and investments.

The written report of the Department was received by the Council.

Committee on Auditing and Appropriations

The minutes of the Auditing and Appropriations Committee meeting of September 9, 1983 was presented by Dr. Abromowitz.

Dr. Abromowitz reviewed in detail the preliminary drafts of the 1984 budget proposals and the projections for income and expenditures during

continued on page 943



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Council Proceedings

continued

that year. A second budget proposal will be presented at the next Council Meeting.

A revision of specialty society service charges was recommended by the Committee and was approved by the Council.

Dr. Abromowitz predicted the necessity of a dues increase to take effect in 1985.

The Council approved the Committee's recommendation that Dr. Pfahl be authorized to investigate the possibility of improving and enlarging OSMA physical facilities.

The minutes as a whole were approved and filed.

Department of Education; Specialty Society and Meeting Management

Mrs. Dodson presented the written report of the Department of Education; Specialty Society and Meeting Management. It was filed.

Committee on Education

The minutes of the August 25, 1983 meeting of the Committee on Education were presented by Mrs. Dodson for information.

They were filed.

Committee on Program

The minutes of the August 25, 1983 meeting of the Committee on Program were presented by Mrs. Dodson.

The Council approved the solicitation of advertising for the Annual Meeting program.

The minutes were filed.

Committee on Emergency & Disaster Medical Care

Dr. William H. Gates presented the minutes of the July 6, 1983 meeting of the Committee on Emergency and Disaster Medical Care.

He discussed basic concepts of a "Proposed Policy — Control of Medical Services at the Scene of a Medical Emergency."

The Committee will submit at a later date a final report.

Department of Government Relations

The Department report was presented in writing. The report was filed.

Committee on Geriatric Medicine

Mr. Gillen presented the July 13,

1983 minutes of the Committee on Geriatric Medicine, in the absence of Mr. Fry.

The minutes were filed.

Committee on Cost Effectiveness

The minutes of the July 18, 1983 meeting of the committee on Cost Effectiveness were presented by Mr. Gillen and were filed.

Certificate of Need

Mr. Gillen presented information on the proposed moratorium on Certificates of Need. Proposed legislation (S.B. 269) to establish the moratorium for 8 months was discussed by Mr. Burkland.

Mr. Gillen presented a request from the Ohio Department of Health to provide physician nominees for Certificate of Need criteria development.

Current status of Professional Review Organization legislation was presented by Mr. Gillen.

Department of Development and Member Service

The written report of the Department of Development and Member Services was presented. It was filed.

Task Force on Professional Liability

Mr. Campbell presented the minutes of the August 17, 1983 Task Force on Professional Liability.

The Council approved the Task Force recommendations.

AMA Delegation

Dr. Clarke reported for Ohio's AMA Delegation.

Dr. Pfahl reported on the meeting of the AMA Health Policy Agenda Advisory Committee, held in Chicago, August 29 and 30, 1983.

PICO

Mr. Goodwin announced a gain in the holders in the group primary professional liability coverage plan.

He reviewed the progress of Professionals Insurance Company and American Physicians Life Insurance Company.

Foundation; Students & Residents

Mr. Saslaw discussed his work with

the medical students throughout the state.

He also reviewed the progress of the OSMA Education and Research Foundation.

Department of Health Education

The Department of Health Education report was presented in writing and was filed.

Subcommittee on Impaired Physicians

The minutes of the July 10, 1983 Subcommittee on Impaired Physicians were presented by Mr. Clinger and were accepted and filed.

Committee on Environmental Liaison

A revised statement from the Committee on Environmental Liaison was presented by Mr. Clinger and was approved by the Council.

The statement reads as follows:

"The Ohio State Medical Association is dedicated, in liaison with other health-related organizations, to pursue a course of action that will protect the environment, and thereby the health of people. This course of action has two major priorities, as follows:

- I. To determine whether dangerous levels of contamination exist in the soil, water and air.
- II. To make a concerted effort through education of physicians and the public to prevent contamination of our environment, thus helping to protect the health of people."

Department of Staff Counsel

The Department of Staff Counsel report was presented in writing and was filed.

Mr. Mulgrew presented a memorandum dated September 9, 1983, concerning recent decisions of the Supreme Court of Ohio. A complete report will be published in the *Ohio State Medical Journal*.

Federal Legislation

Current Federal Legislative developments were reviewed by Mr. Mulgrew. Funding of the National Institutes of Health was discussed.

He announced that Dr. Ray W.

continued on page 945

*"I can do things that I
couldn't do for 3 yrs. including
joining the human race again."*

*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

One of many unsolicited letters to Pfizer from an angina patient. While this patient's experience is representative of many, unsolicited comments received, not all patients will respond to Procordia to the same degree.

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for the varied faces of angina

PROCARDIA[®]
(NIFEDIPINE) Capsules 10 mg

*Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA brief summary on adjoining page.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: 1. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

2. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Council Proceedings

continued

Gifford, Jr., of Cleveland, has been nominated by the American Medical Association to serve on the Prospective Payment Assessment Commission, established by the 1983 Social Security reform legislation.

The Council ratified a letter dated August 26, 1983, from Dr. Pfahl to The Honorable John H. Gibbons, Director, Office of Technology Assessment, giving OSMA support to the AMA nomination of Dr. Gifford.

Ad Hoc Committee on Update Meeting

Mr. Mulgrew presented the minutes of the August 10, 1983 meeting of the Ad Hoc Committee to Study Update Meetings and Conferences.

The Committee recommended that district conferences be scheduled in 1984.

The Council approved the recommendation and suggested a nominal registration fee.

Ohio State Medical Board

Mr. Mulgrew discussed Ohio State Medical Board developments.

Hospital Medical Staff Issues

A paper on hospital medical staff issues presented by Mr. Mulgrew at the meeting of the American Association of Medical Society Executives was distributed to the Council.

Department of State Legislation

Mr. Burkland presented the minutes of the September 9, 1983 meeting of the Committee on State Legislation.

The Council approved the Committee's recommendations as follows:

SENATE BILL 257 — HOSPICE LICENSURE — (Fister, D-Cleveland)
The bill would establish standards for licensure of hospices in Ohio. The bill creates a Hospice Advisory Board within the Ohio Department of Health which would set standards for regulation of hospices and makes an appropriation of \$68,000 for the current biennium to support start-up costs of the licensure program.

continued on next page

Council Proceedings

continued

ACTION: Support, and attempt to expand physician representation on the Board.

SENATE BILL 245/HOUSE BILL 446 — OUT-OF-STATE EMTs — (Speck, R-New Concord; Johnson, R-Cambridge) The bill would allow EMTs certified by other states, but not Ohio, to provide emergency care to and transport patients in Ohio.

ACTION: Support, but seek a distance limitation and address issues of reciprocity and medical control.

SENATE BILL 205 — EMTs IN HEALTH FACILITIES — (Valiquette, D-Toledo) The bill would prohibit EMTs from providing care in any health care facility. The bill would limit EMTs to providing emergency medical care at the scene of an accident, illness or injury and in the course of transporting victims to a health care facility.

ACTION: Oppose.

HOUSE BILL 341 — HEALTH CARE COALITIONS — (Mallory, D-Cincinnati) The bill would permit the establishment of health care coalitions that have as their major goal health care cost containment. The bill does not specify who may form a coalition or how many may be formed in an area.

ACTION: Oppose.

HOUSE BILL 471 — HEALTH DATA COMMISSION — (Miller, D-Columbus) The bill would create an independent Health Data Commission within state government, which would require all hospital claims data from all third-party payers for compilation and public disclosure. The bill also would require standardized hospital billing.

ACTION: Oppose.

SENATE BILL 263 — MEDICAL SCHOOL GRANTS — (Speck, R-New Concord) The bill would establish a medical school grant program within the Ohio Student Loan Commission. The purpose of the grants is to recruit physicians into medically underserved areas of Ohio by a loan forgiveness mechanism.

ACTION: Support.

HOUSE BILL 433 — MEDICAL RECORDS — (Pringle, D-Cleveland) The bill would require the preparation of finalized hospital records within 30

days after discharge and to provide a former patient with a copy upon a signed written request.

ACTION: Oppose.

HOUSE BILL 205 — SOCIAL WORK LICENSURE — (Conley, D-Columbus) The bill would establish a licensure board with licensure and regulatory authority over counselors and social workers. At its April meeting OSMA Council adopted a position of neutrality on the bill. Upon deliberation of a request for a change of position from the Ohio Psychiatric Association, the committee reconsidered its previous recommendation.

ACTION: Change position from neutrality to opposition.

PROPOSAL — IMMUNITY FOR MANDATED IMMUNIZATIONS — This request from Dr. Albert May proposes to provide physicians with immunity from liability for injury caused by an act or omission in the administration of any state-mandated immunization of a child.

ACTION: Oppose, but investigate possibility of establishing a vaccine-injury compensation program, as proposed by the American Academy of Pediatrics.

PROPOSAL — MANDATED INSURANCE COVERAGE FOR OUTPATIENT DIABETES EDUCATION — This request from Dr. Kenneth Kreines proposes to require all group health insurance policies to reimburse the cost of outpatient diabetic education programs.

ACTION: Oppose.

The Committee minutes as a whole were approved and filed.

Mr. Burkland related that Mr. Bateson has met with the Attorney General's staff on the Prescription Abuse Data Synthesis (PADS) program.

Certificate of Need Legislation

Senate Bill 269, Certificate of Need legislation, was discussed by the Council.

It was the sense of the Council that the moratorium on construction until October 19, 1983, be supported, but that physicians' offices should be

excluded from regulations of this nature.

Department of Communications

The report of the Communications Department was presented in writing.

The report was accepted and filed.

Department of Marketing & Field Service

The Department report was presented in writing.

The report was filed.

Councilor Reports

The Councilors reported on activities in their districts.

OSMA Auxiliary

Mrs. Brown presented the Auxiliary report and reviewed its fall conference program set for September 14 and 15, 1983.

The membership seminar of the Auxiliary was also discussed by Mrs. Brown.

Ohio Director of Health

Dr. Jackson presented the report of the Ohio Director of Health.

The Director commented favorably on a letter from the Executive Director to Dr. Joseph F. Boyle, President of the AMA, pressing for more emphasis on health education by the medical federation, especially the AMA.

He discussed subjects from toxic waste to the certificate of need moratorium.

Then with regard to the "Certificate of Need" process, he called attention to an August 11, 1983 article in the *New England Journal of Medicine*.

He discussed the certificate of need proposal currently being considered by the Ohio General Assembly.

He reported that resurrection of HSAs is being considered by the Celeste Administration.

Task Force on Health Care

Dr. Irons reported for the OSMA Task Force on Health Care.

He reviewed plans going forward to present OSMA's position to the Governor's Task Force. The next step in developing the position paper will involve the division of the OSMA

Task Force into three groups:

1. Private Practice Plan — IPA concept.
2. Primary Care networks — "gatekeeper" concept.
3. Academic Medicine.

He reported on a meeting with officials of the Ohio Department of Welfare. These officials have requested assistance with programs involving outpatient surgery and for pre-admission certification.

Dr. Irons complimented Mr. Burkland and the legislative staff on the excellence of their assistance to him and to the Task Force.

There being no further business, the Council Meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

Hypnosis Discussion

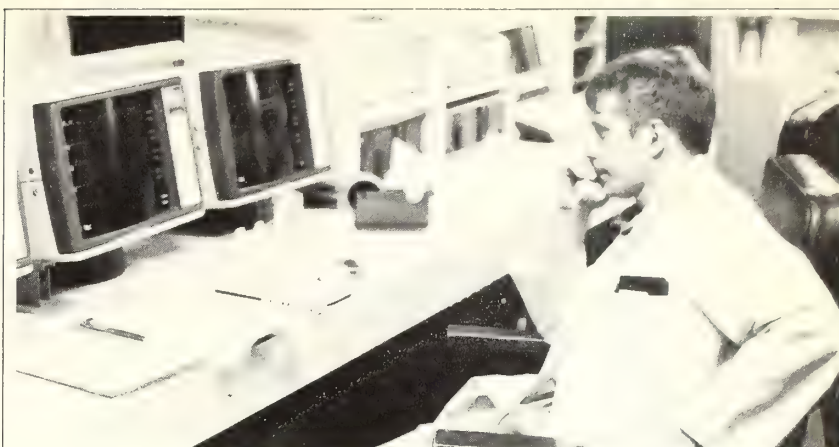
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A. The only problem with hypnosis is the fact that it is not dangerous enough. The biggest myth is that we do the hypnosis. All we do is teach a patient how to achieve hypnosis. The patient could be the best hypnotic subject in the world, but unless they can use it for some useful purpose it does not do any good. That is the purpose of the trained hypnotist. An inadequately trained hypnotist could bring on an abnormal reaction and not be able to handle it. This is to the detriment of the patient. There is no danger in well controlled hypnosis by a trained professional. This is why the American Society of Clinical Hypnosis is very rigid on its training and requirements for membership.

Someone wanting to know more about hypnosis in children should get the book by Gail Gardner, PhD, and Karen Olness, MD — "Hypnosis and Hypnotherapy with Children." It is available through the American Society of Clinical Hypnosis. The address is:

The American Society of Clinical Hypnosis
2250 East Devon Avenue
Suite 336
Des Plaines, Illinois 60018

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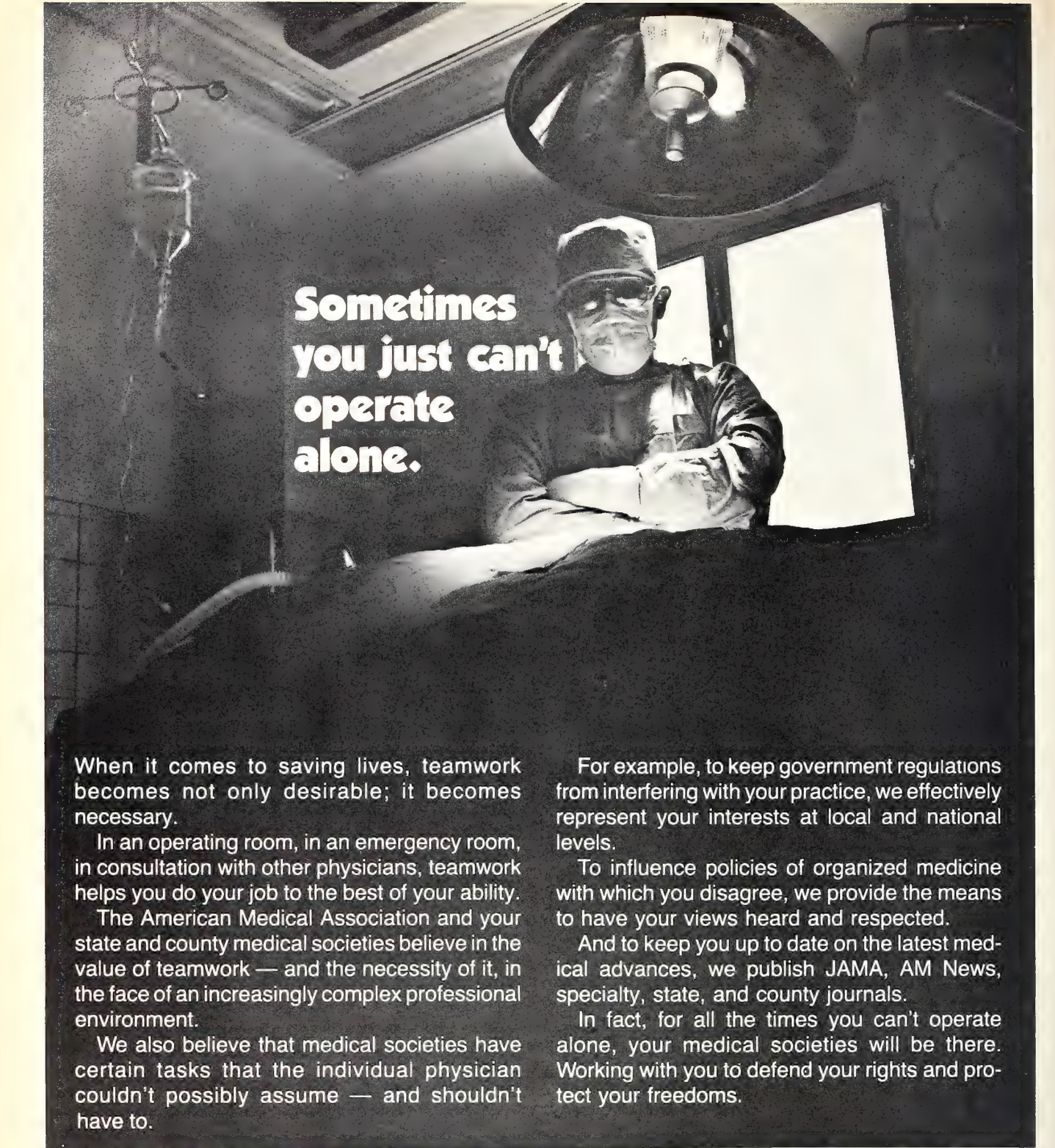


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The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

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☐ I am a member of my county and state societies; please send me information on joining the AMA.

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City _____ State _____ Zip _____

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Obituaries



ALTON J. BALL, MD, Columbus; Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania, 1945; age 70; died September 2, 1983; member OSMA and AMA.

BYRON B. BOYER, MD, Cincinnati; Vanderbilt University School of Medicine, Nashville, Tennessee, 1928; age 81; died September 12, 1983; member OSMA and AMA.

WALLACE H. BUKER, MD, Mansfield; Ohio State University College of Medicine, 1920; age 89; died May, 1983; member OSMA and AMA.

STUART R. DUCKER, MD, Gulf Breeze, Florida; Duke University School of Medicine, Durham, North Carolina, 1944; age 63; died August 14, 1983; member OSMA and AMA.

WILLIAM H. EVANS, MD, Boca Raton, Florida; University of Louisville School of Medicine, Louisville, Kentucky, 1921; age 85; died September 29, 1983; member OSMA and AMA.

RALPH W. GOOD, MD, Cincinnati; University of Cincinnati College of Medicine, 1925; age 83; died September 2, 1983; member OSMA and AMA.

SHIGEKI HAYASHI, MD, Chesterland; Case Western Reserve University School of Medicine, 1938; age 74; died September 12, 1983; member OSMA and AMA.

WINSTON T. LaNEAVE, MD, Peebles; Medical College of Virginia Health Sciences Division of Virginia Community University, Richmond, Virginia, 1932; age 78; died July 6, 1983; member OSMA and AMA.

JOHN P. MARSH, MD, Sidney; Indiana University School of Medicine, Indianapolis, Indiana, 1931; age 78; died September 25, 1983; member OSMA and AMA.

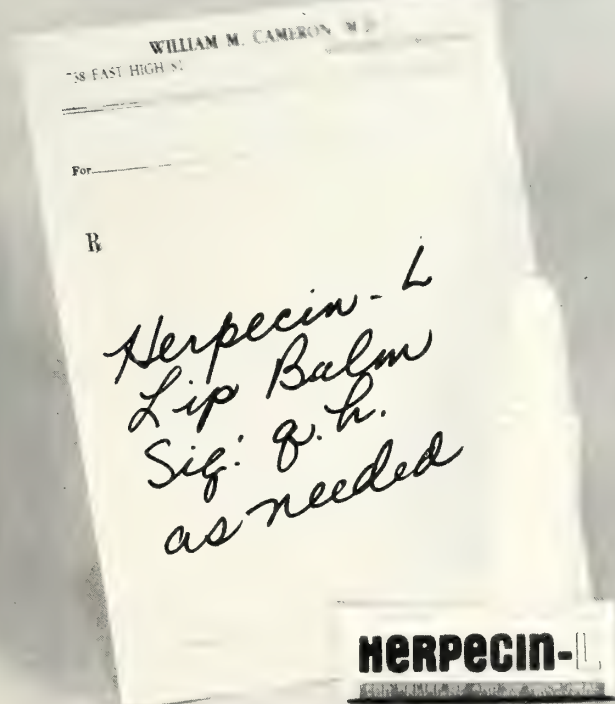
ALEXANDER ORMOND, SR., MD, Southern Pines, North Carolina; University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, 1925; age 85; died September 4, 1983; member OSMA and AMA.

MARIE M. PANCNER, MD, Moreland Hills; Faculte de Medecine de l'Universite, Geneve, Switzerland, 1951; age 60; died September 12, 1983; member OSMA and AMA.

CLYDE N. RAMSAY, MD, Chardon; McGill University Faculty of Medicine, Montreal, Quebec, Canada, 1924; age 85; died September 3, 1983; member OSMA and AMA.

The Memorial Fund of OMERF provides both a meaningful and personal way of paying tribute to the honored memory of the deceased. Memorial gifts may be made payable to the Ohio Medical Education & Research Foundation (OMERF) and sent to the OSMA office. All gifts are acknowledged both to the donor and to the family of the deceased.

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"In the management of *herpes labialis*, Herpecin-L is a **conservative approach** with **low risk / high benefit**." Derm., Miami

"Staff and patients find Herpecin-L remarkably **effective**." Derm., New Orleans

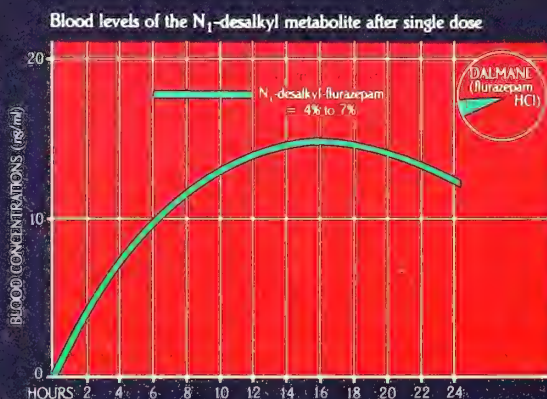
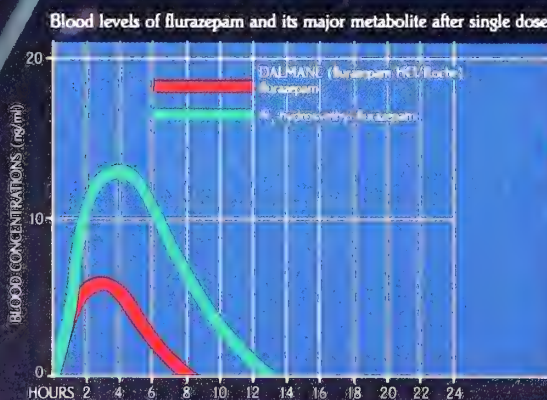
OTC. See *P.D.R.* for information. For trade packages to make your own clinical evaluation, write: CAMPBELL LABORATORIES INC. P.O. Box 812-M, FDR, NY, NY 10150

In Ohio, "HERPECIN-L" Cold Sore Lip Balm is available at all Gray, Revco and SuperRx Drug Stores and other select pharmacies.

Only Dalmane® has the hypnotic profile (flurazepam HCl/Roche) to provide these benefits



The profile



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Two short-half-life hypnotic components appear rapidly and are rapidly eliminated

Dalmane has a pharmacokinetic profile that sets it apart from all other hypnotic agents.

First, there is the active parent compound flurazepam, which appears rapidly in the blood after ingestion and has a half-life of about 2.3 hours. Then there is the major metabolite—N₁-hydroxyethyl-flurazepam—which accounts for 22% to 55% of an average dose in urine. This compound also appears rapidly in the blood, where it has a half-life of two to three hours.¹⁻⁴

Another metabolite accounts for only 4% to 7% of dose in plasma

N₁-desalkyl-flurazepam appears more slowly in serum and has a longer half-life (47 to 100 hours).⁴ This metabolite accounts for only 4% to 7% of an average dose of Dalmane in plasma.¹ It accumulates to steady state within seven to ten days⁴ and disappears gradually after discontinuation of therapy.

The benefits

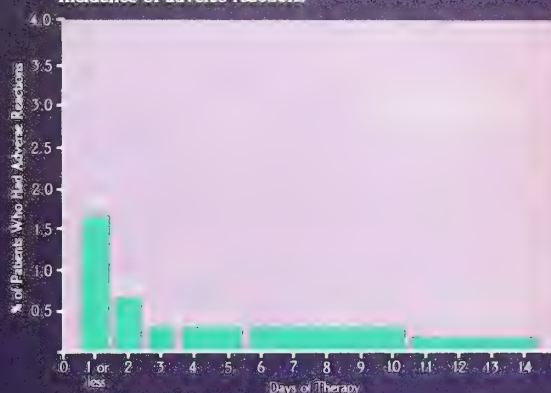
Dalmane (flurazepam HCl/Roche) remains effective yet rarely causes morning hangover

In objective sleep laboratory studies, Dalmane proved more effective than any other hypnotic tested.^{5,6} Patients with insomnia fell asleep 44% sooner on the first three nights of Dalmane therapy and 56% sooner on nights 12 to 14.⁶ Total wake time decreased significantly on the first nights of therapy, and tolerance did not appear to develop for up to 28 consecutive nights of treatment.⁵ Even after four weeks, Dalmane was still significantly more effective than placebo or other hypnotics, some of which lose effectiveness on chronic dosing.^{5,7}

Morning hangover, moreover, was rare with Dalmane. In a study of 2542 patients treated in the hospital, only 3.1% reported adverse reactions after Dalmane treatment. Most of the side effects occurred after the first night of treatment; the incidence diminished as therapy continued.⁸

Caution patients about driving or drinking alcohol during therapy. Because the risks of dizziness, oversedation and ataxia increase with higher dosages in the elderly and debilitated, the dosage should be limited to 15 mg in these patients. Dalmane is contraindicated in pregnancy.

Incidence of adverse reactions



Adapted from Greenblatt et al.⁸

And Dalmane (flurazepam HCl/Roche) avoids rebound insomnia

If patients sleep worse when medication is discontinued than they did before treatment began, the value of hypnotic therapy is clearly questionable. Such rebound insomnia has been reported with certain hypnotics that have short half-lives.⁹⁻¹² Yet this problem does not occur with Dalmane as proven in eight of eight sleep laboratory studies.¹¹ Even after two weeks following discontinuation of Dalmane, rebound insomnia had not occurred.⁵

Dalmane. The complete hypnotic that stands apart from all others.



Dalmane®
flurazepam HCl/Roche
15-mg/30-mg capsules

stands apart

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kaplan SA et al: *J Pharm Sci* 62:1932-1935, Dec 1973. 3. Greenblatt DJ et al: *Clin Pharmacol Ther* 17:1-14, Jan 1975. 4. de Silva JAF, Bekersky I, Puglisi CV: *J Pharm Sci* 63:1837-1841, Dec 1974. 5. Kales A et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 6. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977, and Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 7. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 8. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 9. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 10. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 11. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 12. Greenblatt DJ et al: *Sleep* 5(Suppl 1):S18-S27, 1982.

Dalmane®
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. Adults: 30 mg usual dosage; 15 mg may suffice in some patients. Elderly or debilitated patients: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



New Members

CUYAHOGA (Cleveland unless noted)

Rogina Abdelsayed
Virginia Banks
Reginald T. Bulkley
Scott R. Burg
Marie C. Carlin
Thomas H. Carter
Mark A. Carwell
Scott Changchien
George S. Davis
John M. Draganescu, Philadelphia
John E. Easa
Dennis Lee Edwards, Lakewood
George Eisele
Michael D. Eppig
Bruce J. Feldman
Dennis W. Fera
Maryann Fitzmaurice
Deborah Geismar
Richard M. Goldberg
Robert E. Gress
Richard A. Helffrich
John G. Heller
Danl K. Hellerstein
Graham W. Hoffman, Jr.
Benjamin E. Huang
Brian D. Johnson, Loma Linda
Geoffrey Joseph, New Huntingdon
Satish M. Juman
William E. Katzin
Ronald P. Kaufman, Jr., Arlington
Patricia J. Kellner, New Haven
Colin P. Kerr
Bradford D. Kney, Philadelphia
Matthew J. Kraay, Plymouth
Thomas E. Kuivila, Portland
Richard H. Lash, Ann Arbor
Kevin J. Lawson
Byung Im Lee
Barry D. Lessin
Chin-Huei Liao
Townsend G. Lowe
James E. Lundeen, Forest Park
Steve E. Mancill
Timothy B. Mapstone
Donald C. Martin
Ferinand E. Massari, Philadelphia

Jerome E. McQueen, La Jolla
David M. Melamed, St. Louis
George R. Moro
Jon B. Morris, Arlington
Thomas J. Mullin
Kathleen R. Neal, Salt Lake City
Randall B. Peters, Houston
Stephen Pilipshen
Howard Potash, Pepper Pike
Steven C. Presser, Chicago
Robert A. Raybin, Chicago
Robert H. Reeves, Lakewood
Anthony D. Retikas, New York
Jeffrey A. Ross, Chicago
William A. Rowane
Rudolph B. Rustin, III, Charleston
Roknedin Safavi
Percival D. Seaward
Ermias Seleshi
Wendy M. Shaw
Richard Arthur Simms
Morton J. Singer, Jr., Columbia
David F. Smith
Betsy E. Soifer, Lakewood
William F. Spencer, Ann Arbor
Haraldine A. Stafford
James M. Stark
William P. Steffee
Jeremiah Stein
Keith R. Stephenson
Danl M. Stingl, Richmond
Alexander A. Stratenko, Philadelphia
Raymond Taylor
Laura K. Tenner
Helen D. Tramosch, West Hartford
Anthony J. Volpe, Columbus
Jay Wenger
James C. Wickwire
Thomas S. Wilson
Hagop Youssoufian, Worcester

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Ashwani K. Bindal
Beth A. Boyles
William Buser
Steven M. Callihan
Hall Canter
Steven K. Dankle, Dublin
John Dell
Paul F. Gatens
Timothy L. Herrick
Keith H. Kuppler
Marek Lorenc
Stephen Lucero

continued on page 955

Fifty Years in Medicine

Congratulations!

Editor's Note: The Ohio State Medical Journal wishes to join the Ohio State Medical Association in congratulating those physicians who, this year, have been in the practice of medicine for fifty years.

Allen County

Andrew M. Barone, *Sarasota, Florida*
 Frederick Peterson Berlin, *Lima*
 Roger L. Tecklenberg, *Lima*

Ashtabula County

Walter John Brown, *Pittsboro, North Carolina*

Athens County

Elizabeth C. Hoover, *Athens*

Belmont County

James Joseph Arbaugh, *Martins Ferry*
 James John Del Vecchio, *Martins Ferry*
 Werner Grauberg, *Bellaire*

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Luvern Carl Garling
Spokane, Washington

Carroll County

Plinny S. Whiteleather, *Minerva*

Champaign County

Francis Robert Grogan, *Urbana*

Clermont County

Frederick P. Baurichter
Cincinnati
 Carl Augustine Minning
Batavia

Columbiana County

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 Alexander S. Fisher, *East Liverpool*

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Garry G. Bassett
 Robert Richard Blondis
 John Henry Budd
 Harold Francis Burkons
 William Earl Chaikin
 Ben G. Chapman
 Herbert E. Christman, *Sun City, Arizona*
 Elmer Ernest Collins
 George W. Crile
 George Haskel Curtis, *Pinehurst, North Carolina*
 Daniel V. Dougherty, *Ft. Lauderdale, Florida*
 Carl Ellenberger
 Albert J. Hart, *Pompano Beach, Florida*
 William Wolf Herman, *Shaker Heights*
 Gerhard Hoffman
 Robert Marshall Hosler
 Anthony John Lelbach
 Dezso Levendula
 Joseph J. Major
 John Walter Martin
 Robert Joseph McCaffery
 Nintcho G. Nintcheff
 Herschel H. Pevaroff
 Frank Mathew Rogers
 Brant Burdell Sankey
 Ilse Lotte Seidemann
 Thomas Albert Shehan, *Scottsdale, Arizona*
 Paul Robert Siegel
 Emil Alfred Steiner

Alvyn Weiss Tramer

Maxwell Spencer Udelf, *Aurora*
 Leo Walzer
 John Eli Williams, *Asheville, North Carolina*

Darke County

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 Paul Gish Lenhart, *Arcanum*
 Daryl McCoid Parker, *Greenville*

Delaware County

Maxwell William Livingston, *Sunbury*

Erie County

Eugene Julius Martos, *Sandusky*

Fairfield County

Victor A. Simiele, *Lancaster*

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Louis Ira Adelman
 Donald Judson Alspaugh
 Elizabeth Rowland Aplin
 George F. Collins, *Worthington*
 Horace B. Davidson, Sr., *Guysville*
 Corinne Terrel Dryer
 John Gersten
 Roger E. Heering
 Albert Kostoff
 Anthony Ruppertsberg (Deceased)
 Maurice B. Rusoff

continued on next page

Congratulations!

continued

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Geauga County

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Greene County

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Guernsey County

James Alfred L. Toland, *Cambridge*

Hancock County

Donald Richard Brumley, *Findlay*

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William Arthur Altemeier

Henry Clay Beekley

Joseph John Bell

Richard Daniel Bryant

Christine Carter

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Ralph B. Cunningham

Dorothy L. Ferris

Joseph Nathan Freiden, *Cape Coral, Florida*

Raymond Louis Hilsinger, *Tucson, Arizona*

Aloysius Joseph Huesman (Deceased)

Roy Louis Kile, *Lantana, Florida*

David L. Lerner

Esther Clare Marting, *New Richmond*

Charles Hobart Moore

Charles Louis Pfeiffer

Carl Ellsworth Roush

Nelson William Ryan

Bernyce Tavel Safer, *Sun City Center, Florida*

James A. Schaal

Harold Saul Schiro

William Charles Schmidter

Jan Schwarz

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Robert J. Weinrich, *Massillon*

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Harvey Alexander Karam

Joseph Stoner Lichty

Louis Sheinin

George Atanasov Tabakov

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Amanio Primo D'Amore, *Masury*

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Charles Michael Stone, *Ft. Myers, Florida*

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Van Wert County

Floyd Alton McCammon, *Van Wert*

Washington County

Edgar Northrup, *Marietta*

Williams County

Russell K. Ameter, *Bryan*

New Members

continued

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Richard J. Marina
Kathryn G. McKee
John D. Nelson
John F. O'Leary
Leonard Quick
Thomas C. Ransbottom
Susan Romans
Marwan Rusan
Ann Diller Snyder
Ronald B. Taylor
Mary C. Wassell
Stephen L. Wee
Howard Wiles
Peter B. Yeldell

GALLIA

Rebecca L.T. Strafford, Gallipolis

HAMILTON (Cincinnati unless noted)

John D. Adler
David L. Broomall
Chandu Budev
Bradley Busacco
Albert A. Buytendorp
David H. Cloud, Jr., Fort Wayne
Richard Craven
Judith S. Daniels
Kathleen Flohr
Deborah I. Friedman

Richard J. Fry
Prakash Goyal
Camille C. Graham
Cynthia M. Harper
Gregory L. Isaac
Frederick G. Jenkins
Sung S. Kim
Michael R. Kirkwood
Peter G. Kotcher, Reading
Shun P. Lim
John D. Looper, Indianapolis
John P. Lutz
Michael A. Martin
Katherine L. Maurath
Christine L. McHenry
Susan L. Merwin
Farooq Mirza
William H. Pearce
Phillip L. Potter
Alan V. Safdi
Jay J. Schmidt
Marcia Slomowitz
K.S. Starks
Alan M. Tarshis
Linda M. Tracy, Akron
Eugene C. Wells
Robert B. Werner

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Victor Cummins
Umesh A. Golani
Richard J. Morgan

E. Dorinda Shelley
Walter B. Shelley
Patrick W. White

MAHONING

(Youngstown unless noted)

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Earl F. Elowsky, Girard
Glenn Kluge
David W. McMillan
Rona Keiko Nakamoto
Graciela Pozo, Poland
Robert Odell
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PPOs fair well

Preferred provider organizations (PPOs) recently earned favorable remarks from the Justice Department, alleviating some fears that this newest form of alternative health care delivery system might be a target for future antitrust actions.

The department, recently asked to review two PPO proposals (one planned for Southern Florida and the other for New Jersey), issued two letters, both saying the PPO concept has the potential to benefit the public by creating more competition in the health care industry.

While speaking favorably of the two PPOs in question, the Justice Department warned that if a large percentage of any one area's physicians or hospitals were to sign up for a PPO, more consideration would have to be given to that case, in order to determine if the PPO was helping or hurting competition.

CLASSIFIED ADS

Employment Opportunities

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The Bellevue Hospital
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FAMILY PRACTICE CLINIC — EASTERN OHIO: Need board eligible/certified family practitioners to join well established medical practice in small eastern Ohio community. Guaranteed, competitive salary and vacation. Contact: Village Medical Clinic, 1814 Enslee Road, Coshocton, Ohio 43812 or call 614/622-7497 after 7:00 P.M.

Rates: \$5 per line. Display classified: \$7 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat \$7 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 1st day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, *The Journal*.

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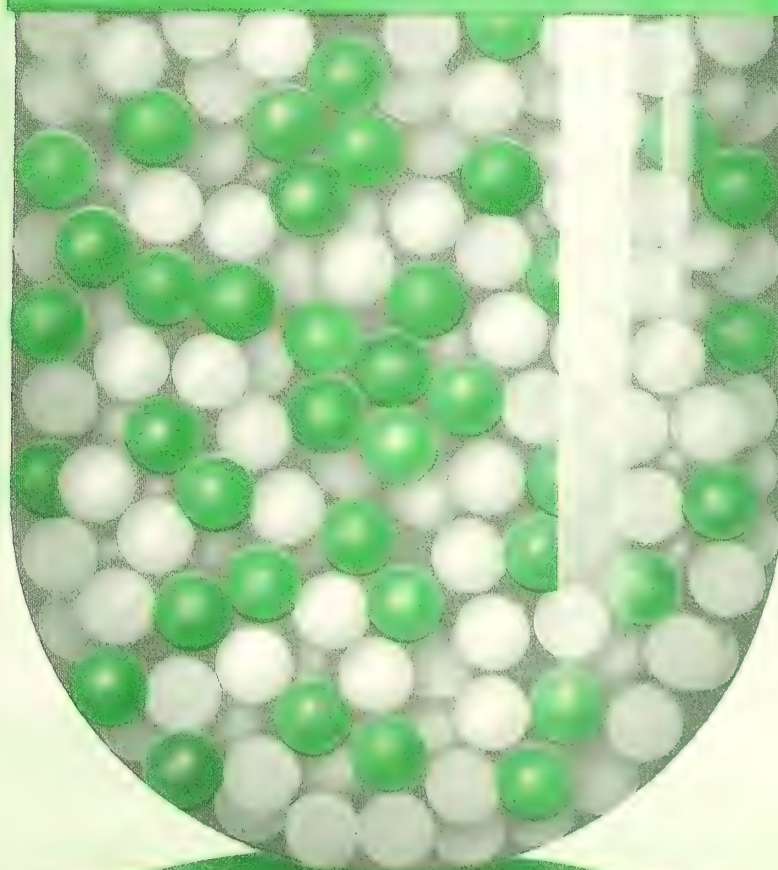
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RU-TUSS[®] II

sustained release capsules

Before prescribing, see complete prescribing information. The following is a brief summary.

DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.

INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage in pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated intestinal obstruction, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

Slight to moderate drowsiness occurs relatively infrequently with Chlorpheniramine Maleate. Other possible side effects common in antihistamines in general include perspiration, chills, dryness of mouth, nose and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

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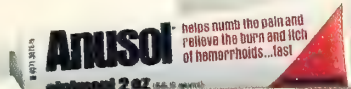
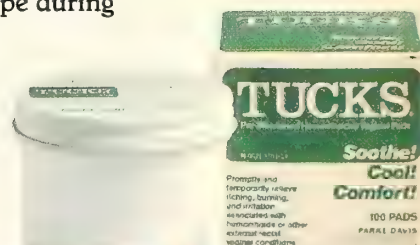
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PR Practice

Communication with your
staff, your patients, your
public

Do Your Patients Know *Why* You Charge What You Charge?

By Rebecca J. Doll

"So you work for doctors, huh? Rich guys, doctors. I can't believe what they charge! Why just a few weeks ago, I went to my doctor for this rash and for headaches and he/she spent about ten minutes with me and charged me \$80! Can you believe it? And then there was the time my Aunt Betty . . ."

And so it goes. You've heard it before and you'll hear it again — as will those of us who work in your behalf — at cocktail parties, at church, at the supermarket, on the golf course, at PTA meetings or just about any social gathering, you name it. Eventually, someone will mention the high cost of health care and that will inevitably lead to the horror stories involving Aunt Betty, Uncle Al or cousin George's nephew, twice removed.

Everyone seems to have a tale to tell about the high cost of medical care these days, but, like the weather, no one seems quite sure what to do about it, including my friend who had finished his "Aunt Betty" story and was launching into the yukky details of his rash, which I noticed, seemed to be healing quite well.

Having been the victim of one too many Aunt Betty stories that evening, I asked my friend to recount his experience at the doctor's office. After

listening to the details and questioning several points, I said to him, "Let's see, you had this rash and headaches which were keeping you off work. So you were losing money. It got so bad, you called the doctor and he worked you into his busy schedule that same day. After all, you've been his patient for 10 years. You waited less than 15 minutes in the reception room. The nurse checked you in, took your blood pressure, temperature, pulse, checked your weight and talked with you a while to update your medical history. The doctor came in and asked you a few questions about any allergies you might have and if you had been exposed to any chemicals. He looked at your eyes, your ears, your throat and asked you to explain your headaches, their frequency and so forth. He asked you about eating and sleeping habits, noting from your chart that you had gained ten pounds and that you still had not quit smoking per his recommendation. He looked at the rash and told the nurse to take blood samples and a couple of other tests. Then he left. The nurse took the tests, left, then came back with some ointment and pills. She gave you written instructions on how to take both and said the doctor felt it was nothing serious and would call you about the tests after they were

completed, which he did two days later. He indicated the tests showed nothing serious but that it might be wise if you lost the ten pounds, tried to cut back on your smoking, tried not to take your work worries home with you and got more sleep. He told you to come to his office for more ointment if you needed it. And he sent you a suggested diet, plus a list of programs to help you quit smoking. You say now, your headaches are gone, your rash is healing nicely and you haven't missed any work since your doctor's appointment. And you paid \$80, \$55 of which was reimbursed by your insurance company."

He finally admitted to me he hadn't thought of it quite that way and hadn't taken into account all the doctor and his staff had done, because "I guess nobody ever explained it to me that way. Wonder why?"

Why indeed? Unless patients are told that there is more to the care you give them than the 15 minute office visit, how can they be faulted when they complain about what they consider to be an outrageous bill? And with the cost of medical care continuing to rise, it will become more important to explain not only what

continued on next page

PR Practice

continued

your care entails, but how you arrive at your fees, especially if you want to keep your patients.

According to a patient opinion survey conducted by *Medical Economics* magazine, patient loyalty is in sharp decline. Over 59% of the people surveyed indicated they had switched doctors recently for various reasons, such as "rotten bedside manner," "noncommunicative," "evasive," and "never on schedule."

But what's more revealing is that indications are that the cost of health care is becoming a strong consideration in decisions to choose a new, or stay with a current, doctor. Among the reasons cited for switching doctors was "questionable billing practices." In fact, 23% of the respondents said they had dropped a doctor at one time because his fees were too high. Twenty-three percent also said they would drop their current doctor if they could get less expensive care from another physician or group. And 19% said they had postponed or cancelled appointments because they were short of cash. Further findings indicate more patients today support prepaid care arrangements such as HMOs because they are supposed to be cheaper. Patient support for fee-for-service medicine is being eroded by their concerns about rising health care costs. More patients today indicate support for government regulation of fees than ever before. And more patients are turning to non-MDs for care at less cost.

Among all of the bad, there is also good news. Apparently physicians are trying a lot harder to hold down their patients' medical care expenses than they were six years ago. The *Medical Economics* survey showed that only 11% of the respondents feel their doctor does nothing to help them save money, as compared to 54% in 1976. Ways in which doctors help them hold

down costs include: "accepting as full payment whatever amount of patient's bill is covered by insurance," "forgetting to charge for one or more visits," "including extra services such as injections or lab work in regular fee," "giving free samples of medication," and "treating two or more family members and charging for one."

As the survey points out, "some of the data have less to do with the individual doctors' performance than with broad changes in medical practice and health care delivery. There's not much you can do to reverse the movement toward group-based practice, convenience clinics, consumerism and alternate financing systems."

But there are steps you can take to educate your patients about health care costs and plenty you can do to keep your own practice thriving amid the changes:

- Explain charges to patients,

- Provide for assistance in completing insurance forms.
- Talk with, not to, your patients. Let them know how much time and effort goes into your care of them, beyond the time you spend in the office visit.
- Try not to appear rushed in the office or on hospital rounds, even if you are. A patient is less likely to complain about a bill if he or she feels she was given an appropriate amount of time. Appearing rushed makes the patient feel rushed — and cheated.
- Discuss your fees ahead of time, especially if costs are likely to be significant. But bear in mind that what may not be significant to you, may represent a week's pay to a patient.

And remember. The more you talk with your patients, about their care and about issues such as costs, the more they feel cared for and the more confidence they have in you. And

Indications are that the cost of health care is becoming a strong consideration in decisions to choose a new, or stay with, a current doctor.

verbally and/or by itemized billing. Let them know if laboratory tests, medications and so forth are included.

- Use posters and brochures, such as those available from the OSMA Department of Communications, to explain to patients their role in rising health care costs and how their lifestyles may affect costs.
- Post a notice in your waiting room offering to discuss fees with your patients.

confident, cared for patients, rarely switch physicians, for any reason.

Rebecca J. Doll is an Associate Executive Director of OSMA, and Director of its Department of Communications.

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